FINANCIAL REPORTING GUIDE FOR RBHA CONTRACTORS

Effective Date October 1, 2016

TABLE OF CONTENTS

ACRONYMS

ACA	Affordable Care Act
ACOM	AHCCCS Contractor Operations Manual
AHCCCS	Arizona Health Care Cost Containment System
AICPA	American Institute of Certified Public Accountants
AIHP	American Indian Health Program
ALTCS	Arizona Long Term Care System
AMPM	AHCCCS Medical Policy Manual
A. R. S.	Arizona Revised Statues
BH	Behavioral Health
CER	Contractor Expenditure Report
CFR	Code of Federal Regulations
CMS	Center for Medicare and Medicaid Services
CRS	Children's Rehabilitative Services
DHCM	Division of Healthcare Management
DHHS	Department of Health and Human Services
DOI	Department of Insurance
D-SNP	Dual Eligible Special Needs Plan
FAC	Federal Audit Clearinghouse
FAQs	Frequently Asked Questions
FASB	Financial Accounting Standards Board
FFS	Fee-For-Service
FPL	Federal Poverty Level

FQHC/RHC	Federally Qualified Healthcare Centers/Rural Healthcare Clinics
FQHC/RHC LA Look-Alike	Federally Qualified Healthcare Centers/Rural Healthcare Clinic
GAAP	Generally Accepted Accounting Principles
GAGAS	Generally Accepted Governmental Auditing Standards
HCSO	Health Care Service Organization
IBNR	Incurred But Not Reported
ICD	International Classification of Diseases
IEP	Individual Education Plan
MHBG	Mental Health Block Grant
PCP	Primary Care Physician
PCP Parity	Primary Care Physician Parity
PH	Physical Health
PL	Public Law
PPC	Prior Period Coverage
PPS	Prospective Payment System
RBUC	Reported But Unpaid Claim
RTC	Residential Treatment Center
SABG	Substance Abuse Block Grant
SED	Serious Emotional Disturbance
SFAS	FASB Statement of Financial Accounting Standards
SMI	Seriously Mental Ill
VBP	Value Based Purchasing

DEFINITIONS

ADMINISTRATIVE COSTS
Administrative expenses incurred to manage the health system, including, but not limited to provider relations and contracting; provider billing; accounting; information technology services; processing and investigating grievances and appeals; legal services, which includes legal representation of the Contractor at administrative hearings; planning; program development; program evaluation; personnel management; staff development and training; provider auditing and monitoring; utilization review and quality assurance. Administrative costs do not include expenses incurred for the direct provision of health care services, including case management, or integrated health care services.

ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL
Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level.

ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL
Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level**.**

AFFILIATE
Refer to Related Party Transactions definition.

AHCCCS
The Arizona Health Care Cost Containment System is a State agency, as described in A.R.S. Title 36, Chapter 29, which is responsible for the provision of hospitalization and medical care to members through contracts with Contractors. AHCCCS is Arizona's Medicaid program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program.

AHCCCS CONTRACTOR OPERATIONS MANUAL
The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.

BEHAVIORAL HEALTH DIAGNOSIS
Behavioral health diagnoses are identified as "mental disorders" in the latest ICD code set in use.

BLOCK GRANT
Federal monies allocated to states, cities or counties for distribution to community groups, charities and other social service providers, most often administrated under the allocated agencies rules and regulations.

CAPITATION
Payment to a Contractor by AHCCCS, of a fixed monthly payment in advance per eligible member, for which the provider provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.

CARE MANAGEMENT
Care Management is an administrative function of the Contractor and not a billable service nor can Care Managers bill for covered behavioral health services including the day-to-day duties of case management. See also AMPM 1020.

CONTRACTOR
An organization or entity that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. §36-2904 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.

CONTRACT YEAR
The period from October 1 through September 30.

COST SHARING
Contractor payment on behalf of behavioral health recipients for Medicare and private insurer costs, including premiums, deductibles and coinsurance.

DAY
Calendar day unless otherwise specified.

DURABLE MEDICAL EQUIPMENT
An item or appliance that is not an orthotic or prosthetic and that is designed for a medical purpose; is generally not useful to a person in the absence of an illness or injury; can withstand repeated use; and is generally reusable by others.

EMERGENCY MEDICAL CONDITION
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

EMERGENCY SERVICES
Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

ENROLLMENT
The process by which an eligible person becomes a member of the Contractor's plan.

EPISODE OF CARE
The period between the beginning of treatment and the ending of behavioral health services for an individual. Within an episode of care, a person may transfer to a different service, facility, program or location. The beginning and end of an episode of care is marked with a demographic file submission. Over time, an individual may have multiple Episodes of Care.

FEDERALLY QUALIFIED HEALTH CENTER
A public or private non-profit health care organization that has been identified by the Health Resources and Services Administration and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(1)(B) of the Social Security Act and received funds under Section 330 of the Public Health Service Act.

FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE
An organization that meets the eligibility requirements of an organization that receives a Public Health Service Section 330 grant, but does not receive grant funding.

FEDERALLY QUALIFIED HEALTH CENTER/REGIONAL HEALTH CENTER VISIT
A face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

FEE-FOR-SERVICE
A method of payment to registered providers on an amount per service basis.

HOME HEALTH
Health and supportive services provided in a Title XIX/XXI member's home. This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis.

INCURRED BUT NOT REPORTED CLAIMS
Incurred but not reported liability for services rendered for which claims have not been received.

INPATIENT
A patient who is provided with room, board, and general nursing services in a hospital setting and is expected to occupy a bed and remain at least overnight.

INTEGRATED RBHA
An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid or Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.

MANAGED CARE
Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.

MANAGEMENT DECISION
The evaluation of the audit findings and corrective action plan and the issuance of a written decision to the auditee as to what corrective action is necessary.

MANAGEMENT SERVICES AGREEMENT
A type of subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.

MEDICAL EXPENSE
Expenses reported through fully adjudicated encounters and sub-capitated/block purchase expenses incurred by the Contractor for covered services with dates of service related to the contract year being reconciled.

MEDICAL SERVICES
Medical care and treatment provided by a Primary Care Provider, attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.

OUTPATIENT
A patient who is not confined overnight in a health care institution.

PHARMACY
An establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist, who is registered pursuant to A.R.S. Title 32, Chapter 18.

PHYSICIAN SERVICES
Services provided within the scope of the practice of medicine or osteopathy, as defined by State law, or under the personal supervision of an individual, licensed under State law to practice medicine or osteopathy. Physician services exclude those services routinely performed and not directly related to the medical care of the individual patient.

PRIMARY CARE PHYSICIAN PARITY
The Patient Protection and Affordable Care Act (ACA) requires that the Contractor pay qualified primary care providers (and other providers specified in ACA) fees that are no less than the Medicare fee schedule in effect for calendar years 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes.

PRIOR PERIOD COVERAGE
The period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility (usually the first day of the month of application) to the date the member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1.

PROVIDER
A person or entity that contracts with a Contractor to provide covered services directly to members according to the provisions A.R.S. 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. 36-2901.

RATE CODE
Eligibility classification for capitation payment purposes.

RECEIVED BUT UNPAID CLAIMS
Claims that have been received by the Contractor but have not been paid. A claim is considered received the day it is physically received by the Contractor.

REINSURANCE
A risk-sharing arrangement purchased by the Contractor for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.

RELATED PARTY TRANSACTIONS
Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. Related parties or Affiliates include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

RURAL HEALTH CLINIC
A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.

STATE FISCAL YEAR
The period from July 1 through June 30.

STATE ONLY TRANSPLANT MEMBERS
Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income may become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11.

SUB-CAPITATION
A fixed premium paid by the Contractor to a provider of health care services with which the Contractor has a contract. The provider is at risk for the designated services.

SUPPLEMENTAL SECURITY INCOME (SSI): Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind, or disabled and have household income levels at or below 100% of the FPL.

THIRD PARTY
An individual, entity or program that is, or may be, liable to pay all, or part of, the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in R9-22-1001.

VALUE BASED PURCHASING STRATEGIES
A model which aligns payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality. VBP strategies for this initiative may include any combination of Primary Care Incentives, Performance-Based Contracts, Bundled/Episode Payments, Shared Savings, Shared Risk and Capitation + Performance-Based Contracts purchasing strategies as defined in ACOM 322, RBHAs Value-Based Purchasing Initiative.

1.00 GENERAL INFORMATION

1.01 Purpose and Objective of the Guide

The purpose of the AHCCCS Financial Reporting Guide for RBHA Contractors (Guide) is to set the periodic financial reporting requirements for the contracted Integrated RBHAs (hereafter referred to as Contractors). The primary objectives of the reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist the Contractor in meeting contractual reporting requirements. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor's annual certified audit nor to replace the independent Certified Public Accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported by the applicable Contractor's management on a periodic basis and by the independent Certified Public Accountants on an annual basis.

The contract with AHCCCS requires that Contractors furnish information from their records relating to the performance under the contract. Certain financial and statistical data are outlined in the contract as minimum reporting requirements. AHCCCS has developed a standard set of forms to be used to satisfy the financial reporting requirements as well as guidelines and minimum reporting requirements for the annual audited financial statements. This guide is intended to outline these requirements and also provide examples of required reports in the Appendices to the guide.

Contractors are required to contract with CMS for a Medicare Advantage D-SNP (companion D-SNP) or offer a D-SNP through one of the equity partners (equity D-SNP) in the organization. Refer to ACOM 107 for requirements to operate as a D-SNP.

If the Contractor is a Medicare Advantage Plan licensed through the Arizona DOI or contracts with an equity D-SNP plan that is licensed through DOI, quarterly reporting to AHCCCS is required for informational purposes only. If the Contractor contracts with an equity D-SNP plan certified by AHCCCS or establishes a D-SNP plan certified by AHCCCS, the D-SNP plan is required to submit its quarterly reports to AHCCCS as outlined in Exhibit 9 of its Contract with AHCCCS using the Financial Reporting Guide for Acute Contractors and the related report template for quarterly reporting.

If there are any inconsistencies between this reporting guide and any contract provision, the contract provision shall prevail. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the AHCCCS Finance Manager.

1.02 Effective Dates and Reporting Time Frames

The provisions and requirements of this Guide are effective for reporting periods beginning October 1 of every contract year. As deemed necessary, amendments and/or updates to this Guide may be issued by AHCCCS.

Monthly reporting, when required, is due within 30 days of each month end, using either the Contractor's internal financial statement format or the AHCCCS Reporting Guide format as determined by AHCCCS.

Quarterly reporting is due within 60 days of each quarter end, using the most recent AHCCCS Reporting Guide format.

A draft of the annual audited financial statements, supplemental schedules, and annual reconciliation are due within 90 days of contract year end. AHCCCS must approve the Contractor's draft audit prior to the Contractor's auditors issuing the final audit report and financial statements. The final annual audited financial statements, annual reconciliation, management representation letter, management letter to the board of directors and all other annual financial reports are due within 120 days of contract year end.

If a due date falls on a weekend or a State recognized holiday, reports will be due the following business day. Extensions must be requested in writing and addressed to the applicable Financial Consultant. Requests must be received at least 5 business days prior to AHCCCS' due date and must include the reason for the extension and the revised filing date. Requests for extensions will be reviewed and acknowledged.

See Section 2.00 for a complete listing of monthly, quarterly, and annual filing requirements.

1.03 Sanctions

Pursuant to ACOM 408, failure to file with AHCCCS, accurate, timely, and complete financial statements and related deliverables may result in monetary penalties until such statements or deliverables are received by AHCCCS. In addition, Contractors are subjected to monetary penalties if for misrepresentation or falsification of information furnished to CMS or AHCCCS. AHCCCS may refuse to enter into a contract and may suspend or terminate an existing contract if the Contractor fails to disclose ownership or control information and related party transactions as required by AHCCCS policy.

For sanctions assessed by AHCCCS, the full amount of the sanction will be withheld from the Contractor's monthly payment. Revenue from specific programs will be reduced by the amount of the sanction. The Contractor should ensure that they report the full amount of the program's revenue then report the sanction in the same program as an administrative expense on line 458, Other Administrative Expenses, then disclose on the Statement of Activities Schedule A Disclosure.

2.00 FINANCIAL REPORTING REQUIREMENTS

The table on the following page represents the financial reporting requirements and the applicable due dates. Detailed descriptions of the required reports may be found in Section 3.00 and Section 4.00 of this Guide.

REPORT DUE DATES

REPORT	Monthly Reporting (Only if requested by AHCCCS)	Quarterly Reporting	Draft Annual Financial Reporting	Annual Financial Reporting
Due Date:	**30 days after month end**	**60 days after quarter end**	**90 days after contract year end**	**120 days after contract year end**
Certification Statement	**X**	**X**	**X**	**X**
Financial Statement Template Audit Report		**X**		
Balance Sheet Report - Part A: Assets	**X**	**X**	**X**	**X**
Balance Sheet Report - Part B: Liabilities & Equity	**X**	**X**	**X**	**X**
Statement of Activities	**X**	**X**	**X**	**X**
Annual Statement of Activities Audited by Program and Schedule A Disclosure			**X**	**X**
Title XIX/XXI Statement of Activities Quarterly Summary	**X**	**X**	*	*
Non-Title XIX/XXI Statement of Activities Quarterly Summary	**X**	**X**	*	*
Footnote Disclosure Requirements (AHCCCS format for Quarterlies or GAAP/GAGAS format for audits)	**X**	**X**	**X**	**X**
Ratio Analysis	**X**	**X**	**X**	**X**
Receivables/Payables Report (includes 4.02 and 4.03)	**X**	**X**	*	*
Payables to Providers Report	**X**	**X**	*	*
Other Assets Report	**X**	**X**	*	*
Other Liabilities Report	**X**	**X**	*	*
Value Based Purchasing Report (by provider by year)	**X**	**X**	*	*
Lag Reports – (BH TXIX, BH NTXIX and PH)	**X**	**X**	*	*
Long-term Debt Report (other than Affiliates)	**X**	**X**	*	*
Sub-Capitated Expenses Report	**X**	**X**	*	*
Sub-Capitated Expense Detail	**X**	**X**	*	*
Block Purchases Expenses Report	**X**	**X**	*	*
Block Purchases Expense Detail		**X**		
Prior CY Adjustment Schedules (Bal Sheet & Statement of Activities)		**X**	*	*
FQHC/RHC Member Months Report		**X**		

Parent Company Financial Statements (if applicable)			**X**	**X**
Independent Auditor's Report			**X**	**X**
Single Audit Report			**X**	**X**
Statement of Cash Flows (if required by GAAP/GAGAS)			**X**	**X**
Management Letter and Management Representation Letter				**X**
Annual Reconciliation			**X**	**X**
Independent Auditor's Attestation of Sub-Capitated and Block Expenses Report				**X**
Related Party Transactions				**X**

* Required submissions **only** if audit adjustments have impacted amounts previously reported or Contractor revised financial statements subsequent to the 4th quarter reports submitted to AHCCCS. See Paragraph 4.16.

3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING FORMS

3.01 General Instructions

Financial statements must be prepared and presented on an accrual basis and in accordance with GAAP and all other applicable authoritative literature. Financial reporting by an HCSO for Medicare Reporting must follow statutory accounting rules as prescribed by the Arizona DOI (if licensed by DOI or AHCCCS Financial Reporting Guide for Acute Contractors if certified by AHCCCS).

The Contractor shall submit these forms electronically on or before the due date to AHCCCS via SharePoint using the Financial Statement Reporting Template provided by the DHCM. The date the file is uploaded to SharePoint will be the date used for timeliness purposes. The electronic copy must contain the Financial Reporting Template in MS Excel including all supplemental schedules. The Certification Statement needs to bear all signatures written or electronic and be inserted into the Excel template. If the Contractor opts to use a written signature then the Certification Statement will need to be submitted in PDF format and inserted into the Excel template. Any additional information needs to be submitted in MS Excel. Amounts reported to AHCCCS under this guide are to represent the AHCCCS Contractor business independent of any other line of business in which the Contractor may be engaged. The financial statements must at least separate these lines of business in the form of additional supplemental schedules, if they are not separately presented in the financial statements themselves.

Draft annual audited financial statements and supplemental reports should be completed with all attachments and schedules and be as close to final as possible. There should be only minimal changes between the draft and final submissions. The draft and final audit report, audited financial statements and footnotes should be in accordance with GAAP or GAGAS. Footnotes and supplemental schedules should agree to amounts included in the audited financial statements. Contractors should review the Sarbanes-Oxley Act and consider applying the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five years.

Report line titles and columnar headings are detailed in the report specific paragraphs below. Utilize predefined categories or classifications before reporting an amount as "Other". For any material amounts included in the "Other" category, provide details and explanations in the footnotes regarding the content of the account(s). For this purpose, material is defined as an amount > 10% of the total for each section. For example, if Other Income is reported and it is less than 10% of Total Revenues, no disclosure is necessary. However, if Other Income was 13% of Total Revenues, disclosure is necessary (see Paragraph 3.06 for Footnote Disclosure Requirements).

If information is not available or applicable, write "None," not applicable (N/A), or "-0-" in the space provided.

When a Contractor changes any line item, for a prior quarter, the change must be reported one of two ways: (1) submit corrected prior quarter report or (2) record the change in the current quarter report. An explanation of adjustments made for prior periods are to be disclosed in the Prior Period Footnote. Revisions to a prior period will invalidate the previously submitted report. If material revisions are submitted after the AHCCCS due date, then sanctions may be imposed for untimely or inaccurate reporting.

If there are insufficient instructions for a specific category, the Contractor shall request direction from the AHCCCS DHCM Finance Manager. A perceived lack of instruction is not sufficient grounds for failure to report accurately. AHCCCS has provided the required reporting formats to ensure consistent reporting among Contractors. It is the Contractor's responsibility to ensure that all reports submitted are accurate, complete and timely. Adherence to GAAP is the overriding responsibility of the Contractor. If there is a conflict between GAAP and these instructions, the Contractor should advise the AHCCCS DHCM Finance Manager of such conflict.

3.02 Certification Statement

The purpose of the Certification Statement is to attest that the information submitted in the reports is current, complete, and accurate. The Certification should include the Contractor's name, Contractor identification number(s), quarter ended, preparer information, and Chief Executive Officer and Chief Financial Officer signatures, written or electronic. See Final Template, Appendix A for an example of the Certification Statement.

3.03 Financial Statement Reporting Template Audit Report

The Financial Statement Reporting Template Audit Report lists the required audit criteria that must be passed prior to the submission of quarterly financial statements. If the audit check figures do not match, data should be corrected or an explanation should be provided in writing and submitted with the quarterly financial statement reporting package. See Appendix B for an example of this report.

3.04 Balance Sheet

The Balance Sheet illustrates the financial position of the Contractor as of the reporting date. It is the primary source of information about the Contractor's liquidity and financial stability. See Appendix C-1 for an example of this report.

CURRENT ASSETS are assets that are expected to be converted into cash or used or consumed within one year from the balance sheet date. Restricted assets for the performance bond, contracts, reserves, etc., are not to be included as current assets.

A/C 105 - Cash and Cash Equivalents

Include: Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.

Exclude: Restricted cash (and equivalents) and any cash (and equivalents) pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

A/C 110 - Short-term Investments

Include: Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date.

Exclude: Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

A/C 115 - Capitation and Non-Title XIX/XXI Funding Receivable

Include: Net amounts receivable from AHCCCS for capitation and Non-Title XIX/XXI funding as of the balance sheet date. See Capitation and Non-Title XIX/XXI Funding Receivable Report (Paragraph 4.02) for required detail of this line item. Also include the Health Insurer Fee revenues in this line.

A/C 120 - Reinsurance Receivable

Include: Billed and unbilled reinsurance. See discussion of Reinsurance in Paragraph 5.02.

A/C 122 - Reconciliation/Settlements Receivable

Include: Amounts receivable from AHCCCS for Title XIX/XXI Reconciliations/Settlements. See Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all receivable amounts listed on the Receivables/Payables Report (Paragraph 4.03) for account 122. This also includes provider incentive payments reimbursed by AHCCCS.

Exclude: Amounts **due from providers** relating to value based purchasing initiatives.

A/C 125 - Investment Income Receivable

Include: Income earned but not yet received from cash equivalents, investments, on-balance sheet performance bonds, and short and long-term investments.

A/C 130 - Due from Affiliates

Include: The net amount of receivables due from affiliates expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently for the same Affiliate. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due from Affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts Due from Affiliates resulting from medical claims payable, capitation payable, block payment payable or other medical expense related items and non-current amounts Due from Affiliates.

A/C 135 - Value Based Purchasing Receivable From Providers

Include: Any amounts **due from providers** relating to value based purchasing arrangements between the Contractor and the provider.

A/C 140 - Other Current Assets

Include: The total current portion of any assets (e.g. income taxes receivable) not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item, and should not be netted against the IBNRs. See Other Assets Report (Paragraph 4.04) for required detail of this line item.

OTHER ASSETS

A/C 145 - Performance Bond

Include: All cash and investments pledged to meet the AHCCCS performance bond requirement.

Exclude: Surety bonds or letters of credit that do not represent actual assets of the Contractor.

A/C 150 - Restricted Cash and Other Assets

Include: Cash, securities, receivables, etc., whose use is restricted.

Exclude: Cash and/or investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

A/C 155 - Long-term Investments

Include: Unrestricted investments that are expected to be held longer than one year.

Exclude: Investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

A/C 160 - Non-Current Due from Affiliates

Include: The net amount of receivables Due from Affiliates not expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. Non-current Due from Affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts Due from Affiliates resulting from medical claims payable, capitation payable, block payment payable or other medical expense related items and current amounts Due from Affiliates.

A/C 165 - Other Non-Current Assets

Include: The total non-current portion of any assets not accounted for elsewhere on the balance sheet including any non-current portion of Value Based Purchasing Initiatives. See Other Assets Report (Paragraph 4.04) for required detail of this line item.

PROPERTY AND EQUIPMENT consists of fixed assets including land, buildings, leasehold improvements, furniture, equipment, etc.

A/C 170 - Land

Include: Real estate owned by the Contractor.

A/C 175 - Buildings

Include: Buildings owned by the Contractor, including buildings under a capital lease, and improvements to buildings owned by the Contractor.

Exclude: Improvements made to leased or rented buildings or offices.

A/C 180 - Leasehold Improvements

Include: Capital improvements to facilities not owned by the Contractor.

A/C 185 - Furniture and Equipment

Include: Medical equipment, office equipment, data processing hardware, and software (where permitted), and furniture owned by the Contractor, as well as similar assets held under capital leases.

A/C 190 - Other Property and Equipment

Include: All other fixed assets not falling under one of the other specific fixed asset categories.

A/C 195 - Accumulated Depreciation and Amortization

Include: The total of all depreciation and amortization accounts relating to the various fixed asset accounts.

CURRENT LIABILITIES consists of obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

A/C 205 - Accounts Payable

Include: Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.

Exclude: Amounts due to providers related to the delivery of behavioral and physical health care services.

A/C 210 - Accrued Administrative Expenses

Include: Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (e.g., payroll, taxes). Also include accrued interest payable on debts.

A/C 215 – Payable to Providers

Include: Net amounts owed to providers for monthly Capitation, block payments, other non-FFS payment arrangements payments and pharmacy if not included in IBNR.

Exclude: Capitation amounts payable to AHCCCS as a result of an overpayment. (This amount should be reported in A/C 240 - Other Current Liabilities.)

A/C 220 - Medical Claims Payable

Include: The total will include the total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs). See the discussion on Medical Claims Liability in Paragraph 5.01.

A/C 222 - Reconciliation/Settlements/Profit Limit/General Fund Profits Payables

Include: Amounts payable to AHCCCS for Title XIX/XXI Reconciliations/Settlements, Non-Title XIX/XXI Profit Limit and General Fund profits. This should equal only the sum of all payable amounts detailed on the Receivables/Payables Report for account 222 (Paragraph 4.03). In addition, any amounts **due to AHCCCS** relating to value based purchasing initiatives should be recorded in this account.

Exclude: Amounts **due to providers** relating to value based purchasing arrangements.

A/C 225 - Value Based Purchasing Initiatives Payable to Providers

Include: Current portion of payable amounts **due to providers** relating to value based purchasing arrangements.

A/C 230 - Current Portion of Long-term Debt

Include: The total current portion from the detail listed in the Long-term Debt Report (Other than Affiliates) which will include the principal amount on loans, notes, and capital lease obligations due within one year of the balance sheet date. See Long-Term Debt (Other than Affiliates) Report, Paragraph 4.08.

Exclude: Long-term portion of, and accrued interest on loans, notes, and capital lease obligations.

A/C 235 - Due to Affiliates

Include: The net amount of payables Due to Affiliates expected to be paid within one year of the balance sheet date. Note only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts Due to Affiliates resulting from medical claims payable, capitation payable, block payment payable or other medical expense related items and non-current amounts Due to Affiliates.

A/C 240 - Other Current Liabilities

Include: The total current portion from the detail listed in the Other Liabilities Report, which will include those current liabilities not specifically identified elsewhere (e.g., deferred revenue or income taxes payable). See Other Liabilities Report, Paragraph 4.05. Also include the current portion of the Health Insurer Fee liability in this line.

OTHER LIABILITIES are those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

A/C 245 - Non-Current Portion of Long-term Debt

Include: The total non-current portion from the detail listed in the Long-term Debt report which will include the long-term portion of principal on loans, notes, and capital lease obligations. See Long-Term Debt (Other than Affiliates) Report (Paragraph 4.08) for required detail of this line item.

Exclude: Current portion of, and accrued interest on loans, notes, and capital lease obligations.

A/C 250 - Non-Current Due to Affiliates

Include: The net amount of payables due to affiliates not expected to be paid within one year of the balance sheet date. Note that only the net amount is reported. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to Affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts due to affiliates resulting from medical claims payable, capitation payable, block payment payable or other medical expense related items and current amounts Due to Affiliates.

A/C 255 - Other Non-Current Liabilities

Include: The total non-current portion of Other Liabilities, which will include those non-current liabilities not specifically identified elsewhere. Non-current portion of Value based Purchasing Initiatives should be reported on this line. See Other Liabilities Report (Paragraph 4.05) for required detail of this line item. Also include the non-current portion of the Health Insurer Fee liability in this line.

EQUITY/NET ASSETS includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

A/C 505 - Preferred Stock

Include the total par value of Preferred Stock, or in the case of no-par shares, the stated or liquidation value.

A/C 510 - Common Stock

Include the total par value of Common Stock, or in the case of no-par shares, the stated value.

A/C 515 - Treasury Stock

Include the amount of Treasury Stock reported using the Par Value or Cost Method.

A/C 520 - Additional Paid-in Capital

Include amounts paid and contributed in excess of the par or stated value of shares issued. Also include adjustments from purchases and revaluations recorded in accordance with SFAS No. 141, Business Combinations and EITF 88-16, Basis in Leverage Buyout Transactions.

A/C 525 - Contributed Capital

Include capital donated to the Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.

A/C 530 - Retained Earnings/Net Assets (Liabilities)

Include the undistributed and unappropriated amount of earned surplus. Beginning retained earnings balance for a new fiscal year should agree to the ending retained earnings balance from the previous fiscal year and should remain constant during the fiscal year.

3.05 Statement of Activities

The Statement of Activities encompasses revenue and expenses for Title XIX/XXI, Non-Title XIX/XXI, Federal and County programs for the applicable quarter. The intent of the statement is to capture the revenue of the Contractor and to match that revenue with related expenses by each funding program. Any expense allocation shall be made in a consistent manner and shall be in compliance with the cost allocation plan (refer to paragraph 5.10).

Prospective and PPC member months should be obtained from the BHS Weekly 820 files.

Revenue and expenses shall be reported under the applicable funding program column in the line indicated in these instructions.

Revenue is to be calculated and accrued as follows:

a. Title XIX/XXI revenue should be accrued using the projected number of eligible members provided by AHCCCS multiplied by the approved capitation rates currently being paid, unless the most recent proposed capitation rates were already approved and are awaiting payment. Any deviations from the above must be pre-approved in writing.

b. Non-Title XIX/XXI revenue is to be accrued on a state fiscal year basis using $1/12^{th}$ of the annual allocation (or $1/9^{th}$ of the allocation, if applicable) as reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current. Revisions to the allocation may occur throughout the year, but until the Contractor is notified in writing of any changes, the amount reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current, is the best and most probable estimate of what AHCCCS will pay out. Prior written approval must be obtained from AHCCCS for any deviations from the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current.

c. Other revenue sources should be accrued in accordance with GAAP (e.g. CERs and revenue sources other than AHCCCS).

Calculate BH and PH medical expenses as part of the IBNR calculation and allocate on a consistent basis in accordance with GAAP within each funding program. Refer to the BH Title XIX/XXI, BH Non-Title XIX/XXI and PH Lag Reports (Paragraph 4.07) or more information.

BH and PH medical expenses should be allocated to service line items and to each funding program based on current year service utilization/encounter data. Medical expenses should be allocated to service line items based on sufficient encounter experience. Contractors should use sufficient encounter history (e.g., a rolling 12 months) to allocate block payment expenditures. At the beginning of each contract year for current period allocations, if necessary, limit the usage of prior year utilization/encounter data to a minimal period of no more than six (6) months.

Report BH and PH medical expenses in accordance with contractual requirements, AHCCCS Guides and Manuals, the Behavioral Health Covered Services Mapping Matrix (Appendix H) and the Physical Health Covered Services Mapping Matrix (Appendix I). Administrative expenses shall be reported in conformance with the Contractor's cost allocation plan. Refer to Paragraph 5.10 for more information**.**

See Appendix C-2 and C-2a for an example of the Statement of Activities and Schedule A Disclosure. For revenue and expense lines with an asterisk after the title, Contractors are required to disclose the details on the Statement of Activities, Schedule A Disclosure. Contractors are also required to complete the Title XIX/XXI and Non-Title XIX/XXI Statement of Activities YTD Summaries on a quarterly basis. Refer to Appendix C-2b and C-2c for examples of these reports.

REVENUE

A/C 305 - Prospective Capitation

Include: Revenue recognized on a prepaid basis from AHCCCS for provision of prospective behavioral and physical health care services for AHCCCS eligible members. Also, include revenue received for the provision of Premium Taxes.

Exclude: All other capitation, such as PPC.

A/C 310 - PPC Capitation

Include: Revenue recognized from AHCCCS for the provision of prior period coverage health care services for eligible members.

Exclude: All other capitation, such as Prospective.

A/C 311 - Non-Title XIX/XXI Revenue

Include: Revenue recognized from AHCCCS for the provision of covered BH medical expenses for Non-Title XIX/XXI members and BH expenses for Title XIX/XXI members that are not covered by Title XIX/XXI funding.

A/C 312- Reserved for Future Use

A/C 315 - Specialty and Other Grants Revenue

Include: Revenue earned from specialty and other grants received from AHCCCS. This line is used as directed by AHCCCS for revenue not subject to performance ratio calculations.

A/C 319 – Title XIX/XXI Reconciliation Settlement

Include: Title XIX/XXI reconciliation settlement amounts. Estimated reconciliation settlement amounts should be accrued in the period they are earned. Any adjustments to prior contract years need to be disclosed on the Prior Contract Year Adjustment Report. See Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 320 - Non-Title XIX/XXI Profit Limit

Include: Non-Title XIX/XXI Profit Limit amounts due to AHCCCS. Estimated amounts should be accrued in the period that they are earned. In the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 321 - Non-Title XIX/XXI General Fund Profit Limit

Include: Non-Title XIX/XXI General Fund Profit amounts due to AHCCCS. Profits are not allowed in General fund programs. Estimated amounts should be accrued in the period that they are earned.

A/C 322- Reserved for Future Use

A/C 323 - PCP Parity Cost Settlement

Include: Cost-settlement payments from AHCCCS related to the PCP Parity payment program.

A/C 324 - Health Insurer Fee Revenue

Include: An accrual for the revenue that will be paid to the Contractor from AHCCCS to cover the Health Insurer Fee.

A/C 325 - Investment Income

Include: All investment income earned during the period. Interest income and interest expense should not be netted together.

A/C 330 - Other Income (Specify)

Include: Revenue from sources not identified in the other revenue categories; and as directed by AHCCCS, revenue not subject to performance ratio calculations.

EXPENSES All expenses must be reported net of Medicare/TPL reimbursement, interest and net of quick pay discounts. Refer to the AHCCCS Behavioral Health Covered Services Guide for additional information; and the AHCCCS Covered Services, Acute Care, listed in the AMPM 300, for further information on covered physical health care services and dental services. Use the Behavioral Health Covered Services Mapping Matrix and the Physical Health Covered Services Mapping Matrix for medical expense line mapping information, Appendices H and I, respectively.

Behavioral Health Medical Expenses

A/C 501 - Treatment Services

Include: Treatment services provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services include Counseling, Assessment, Evaluation and Treatment and Other Professional and should be reported on the applicable Statement of Activities Treatment expense line.

Mental Health Services (formerly Traditional Healing) may be provided using SABG or MHBG funding if available.

Exclude: For Title XIX/XXI and State funding, exclude treatment services provided by qualified traditional healers for mental health or substance use problems.

These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

Also for Title XIX/XXI and State funding, exclude Auricular Acupuncture services provided by a certified acupuncturist practitioner pursuant to: A.R.S. 32-3922 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance abuse or chemical dependency.

For SABG and MHBG funding, exclude Testing and Evaluation Services.

For MHBG, exclude Alcohol and Drug Services. For SABG, exclude Multi-systemic Therapy for Juveniles.

A/C 502 - Rehabilitation Services

Include: Rehabilitation services include the provision of educating, coaching, training and demonstrating. These services include Living Skills Training, Cognitive Rehabilitation, Health Promotion and Supported Employment Services. Report these services on the applicable Rehabilitation expense line.

Exclude: For SABG, exclude Cognitive Rehabilitation.

A/C 503 - Medical Services

Include: Medical services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services include Medical Management, Laboratory, Radiology, Medical Imaging and Electro-Convulsive Therapy. Report these services on the applicable Medical Services expense line. Per AMPM 320-T, medications through SABG are limited to those identified by AHCCCS as SABG approved. Also for SABG, Medical Management, Laboratory, Radiology and Medical Imaging are limited to services related to MAT.

Exclude: For State funding, SABG and MHBG, exclude Electro-Convulsive Therapy.

A/C 504 - Support Services

Include: Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services include Case Management, Personal Care Services, Family Support, Peer Support, Home Care Training to Home Care Client, Unskilled Respite Care, Supported Housing and Transportation.

Unskilled Respite Care using may be provided using Non-Title XIX/XXI SMI, SABG or MHBG funding, if funding is available.

Exclude: Interpretive/sign language and Translation expenses. These are treated as administrative expenses and are reported on line 449.

For Non-Title XIX/XXI programs, exclude Home Care Training to Home Care Client.

For SABG and MHBG, exclude Emergency Transportation.

A/C 505 - Crisis Intervention Services

Include: Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings or over the telephone and may include screening, (e.g., triage and arranging for the provision of additional crisis services), counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation. Contractors are responsible for providing 72 hours of inpatient emergency behavioral health services to Title XIX/XXI members with psychiatric or substance abuse diagnoses. For GMH/SA Duals and CRS members, Contractors are responsible for the first 23 hours. Report these services as Mobile, Stabilization or Telephone on the applicable Crisis expense line.

A/C 506 - Inpatient Services

Include: Inpatient services (including room and board) are provided by a DLS licensed Level I behavioral health agency including Hospitals, Subacute Facilities and Residential Treatment Centers. These services include Psychiatric, Detoxification and Professional Inpatient Services and should be reported on the applicable Inpatient expense line under the correct facility type. Inpatient Services may be provided using Non-Title XIX/XXI SMI funding in Subacute and RTC settings if funding is available.

Also include expenses related to IEP driven RTC placements determined by the Contractor to be non-medically necessary but a required service as part of A.R.S. 15-765 and the AHCCCS/ADOE ISA. IEP services are paid with Supported Housing funding.

Exclude: For SABG and MHBG funding, exclude Hospital Inpatient Services.

A/C 507 – Residential Services

Include: Residential services are provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional. Report these services as Behavioral Health Residential Facilities and Room and Board on the applicable Residential Services expense line. Services may be provided at Behavioral Health Residential Facilities using Non-Title XIX/XXI SMI funding if available.

Exclude: For Title XIX/XXI programs, State General Funds, Non-Title XIX/XXI Other, Other Federal, PASRR/ADOH and MHBG SMI, exclude Room and Board. For applicable use of County funding, refer to the IGA.

A/C 508 – Behavioral Health Day Program

Include: Behavioral health day program services are scheduled on a regular basis either hourly, half day or full day and may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs. These programs can be provided to a person, group of individuals and/or families in a variety of settings.

Based on the level/type of staffing, day programs are grouped as Supervised, Therapeutic and Psychiatric/Medical and should be reported on the applicable Behavioral Health Day Program expense line.

Exclude: For SABG, exclude Psychiatric/Medical.

A/C 509 – Prevention Services

Include: Prevention and HIV services promote the health of persons, families, and communities through education, engagement, service provision and outreach. Report these services on the applicable expense line. These services are only allowed with SABG funding.

A/C 510 – Pharmacy

Include: Pharmacy expenses incurred for BH outpatient services.

Exclude: Pharmacy expenses incurred for dental and PH.

A/C 511 – Other Services Not Reported Above

Include: BH expenses not specifically identified in one of the categories defined above. For example, BH VBP expenses should be reported here and disclosed on Schedule A.

A/C 512 – BH FQHC/RHC Services

Include: BH FQHC/RHC services should be recorded to this line if the services meet the definition of a visit **or are incidental to the visit.**

A/C 513 – Specialty and Other Grant Expenses

Include: Specialty and Other Grant Expenses; and as directed by AHCCCS, expenses that are not subject to the performance ratios.

A/C 440 - Reinsurance

Include: Reinsurance earned, billed and unbilled, as of the statement date. See discussion in Paragraph 5.02. **NOTE: AHCCCS treats the reinsurance revenue account as a contra-expense account.**

A/C 442 - Third Party Liability

Include: Revenue from settlement of accident claims or other third party sources. **NOTE: AHCCCS treats the third party liability revenue account as a contra-expense account.**

NOTE: A/C's 440 and 442 should be reported as negative numbers, to allow the Financial Statement Reporting Template to properly net the amounts out of medical expense.

Physical Health Medical Expenses

Hospitalization Expenses include only those expenses for Inpatient hospital services.

A/C 402 - Hospital Inpatient

Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses.

Exclude: Expenses where behavioral health is the principle diagnosis as per ACOM 432 and any prior period coverage hospital expenses.

A/C 404 - Hospital Inpatient, BH Principle Diagnosis

Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses where behavioral health is the principle diagnosis as per ACOM 432. Hospital inpatient expenses related to SMI Integrated members should be reported on A/C 402.

Exclude: Expenses where behavioral health is not the principle diagnosis and prior period coverage hospital expenses.

A/C 406 - Hospital Inpatient, PPC

Include: All contracted or fee for service expenses related to prior period coverage hospital inpatient services.

Exclude: Prospective hospital inpatient expenses and expenses where behavioral health is the principle diagnosis.

Medical Compensation Expenses include compensation paid for physician and non-physician services. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses.

A/C 408 - Primary Care Physician Services

Include: Those expenses for primary care delivery and other practitioners, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This also includes urgent care facility expenses.

Exclude: Any prior period coverage medical compensation expenses. PCP Parity Enhanced Payment Expense.

A/C 409 – Physician Services, BH Principle Diagnosis

Include: Those expenses for physician services related to Behavioral Health services as per ACOM 432. PCP expenses related to SMI Integrated members should be reported on A/C 408.

Exclude: Amounts related to the enhanced PCP parity payments. Enhanced PCP parity should be reported under A/C 415.

A/C 410 - Referral Physician Services

Include: Those expenses for referral (specialist) physician services.

A/C 411 - PH FQHC/RHC Services

Include: PH FQHC/RHC services should be recorded to this line if the services meet the definition of a visit **or are incidental to the visit.**

A/C 412 - Other Professional Services

Include: All other professional services not specifically identified in one of the categories defined above.

A/C 414 - PPC – Physician Services

Include: All expenses related to prior period coverage medical compensation services (i.e., PCP, referral physician, and other professional services).

Exclude: Prospective physician services expenses.

A/C 415 - PCP Parity Enhanced Payment Expense

Include: Enhanced payment amount to a Physician, for example if the payment to the Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported under account 415 is $5, the remaining $15 is reported under account 408

Other Medical Expenses include services provided to members on an outpatient basis. Services include emergency services, pharmacy, lab, radiology, etc. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses for these services.

A/C 416 - Emergency Facility Services

Include: Those expenses relating to emergency room services provided on an outpatient basis.

A/C 417 - Pharmacy

Include: Pharmacy expenses incurred for PH outpatient services.

Exclude: Pharmacy expenses incurred for dental and BH.

A/C 418 - Lab, X-ray and Medical Imaging

Include: Pathology, Laboratory and radiology (medical imaging, x-ray) expenses incurred for outpatient services.

A/C 419 - Outpatient Facility

Include: Outpatient facility expenses incurred for outpatient services.

Exclude: Physician expense for surgery (this should be included in A/C 410 above).

A/C 420 - Durable Medical Equipment

Include: Medical equipment, medical supplies, medical appliances and oxygen expenses incurred for outpatient services.

A/C 421 - Dental

Include: Dental expenses incurred for outpatient services, including outpatient surgery, pharmacy, lab, and radiology specifically related to a dental diagnosis.

A/C 422 - Transportation

Include: Transportation expenses incurred for inpatient and outpatient services, both emergency and non-emergency.

A/C 423 - NF, Home Health Care

Include: Expenses relating to nursing facility (NF) and home health care including durable medical equipment expense incurred in a NF or home health care setting. Examples include: Intermediate Care Facility and Skilled Nursing Facility.

A/C 424 - Physical Therapy

Include: Physical therapy expenses incurred for outpatient services.

A/C 434 - Value Based Purchasing Provider Expenses

Include: Expenses (disbursements/recoupments to/from providers) related to the Value Based Purchasing Initiatives with providers as defined in the definition section of this guide. Expenses should be recorded in the period in which they occurred or were earned. The related balance sheet amounts should be recorded in A/C 135, A/C 225, and/or A/C 255.

Exclude: BH VBP expenses.

A/C 425 - Miscellaneous Medical Expenses

Include: Outpatient expenses not specifically identified in one of the categories defined above.

A/C 426 - Reserved for Future Use

A/C 427 - Reserved for Future Use

A/C 428 - Reserved for Future Use

A/C 429 - Reserved for Future Use

A/C 430 - Reserved for Future Use

A/C 431 - Reserved for Future Use

A/C 438 - Miscellaneous Medical Expenses, PPC

Include: Outpatient expenses incurred for services provided to members in the prior period coverage period. Miscellaneous expenses related to SMI Integrated members should be reported on A/C 425.

Administrative Expenses are those costs associated with the overall management and operation of the Contractor.

A/C 444 - Compensation

Include: All forms of compensation, including employee benefits and taxes, to administrative personnel. This includes medical director compensation, whether on salary or contract.

A/C 446 - Data Processing

Include: Costs other than compensation for internal and external data processing services during the period.

Exclude: Compensation for any internal data processing personnel as this is reported in A/C 444.

A/C 448 - Management Fees

Include: Management fees paid or payable by the Contractor for the current period to a parent or an outside management company.

A/C 449 - Interpretive/Translation Services

Include: Interpretive, sign language or translation services.

A/C 450 - Interest Expense

Include: Interest expense incurred on outstanding debt and interest paid to providers on late claims during the period. Interest income and interest expense should not be netted together.

A/C 452 - Occupancy

Include: Occupancy expenses incurred, such as rent and utilities, on facilities that are not used to deliver health care services to members.

A/C 454 - Depreciation

Include: Depreciation on those assets that are not used to deliver health care services to members.

A/C 455 - Care Management

Include: Care Managers expenses incurred for activities performed as defined in Contract and AMPM 1020.

A/C 456 - Marketing

Include: Expenses related to any form of exchange whereby the intent is to promote or increase the membership of the Contractor.

A/C 458 - Other Administrative Expenses

Include: Administrative expenses not specifically identified in the categories above.

A/C 459 - Encounter Evaluation Sanctions

Include: Encounter Evaluation Sanctions assessed for not meeting the annual required contractual requirement of 85%. See paragraph 5.08 for additional information.

A/C 460 - Administrative Expense from Specialty and Other Grants

Include: Administrative expenses from Specialty and Other Grants activities. This line is used as directed by AHCCCS for administrative expenses not subject to performance ratio calculations.

A/C 610- Profit/(Loss) from Other, Non AHCCCS and Non-operating

Include: The net amount of any profit/(loss) from received from sources other than AHCCCS or that cannot be classified as Specialty and Other Grants,

should be reported here. These amounts are not figured into the Performance Ratios, Title XIX/XXI Reconciliations and Non-Title XIX/XXI Profit Limit Analysis. (e.g. Contractor assessed Sanctions and Community Reinvestment)

N/A *Provision for Income Taxes*

Include: Provision for income taxes for the period, including taxes associated with the Health Insurer Fee.

N/A *Provision for Premium Taxes*

Include: Provision for premium taxes for the period.

N/A *Provision for Health Insurer Fee*

Include: Provision for Health Insurer Fee for the period. Expenses should be allocated among the Title XIX/XXI programs based on previous year's revenue. The Health Insurer Fee reimbursement is only applicable to Title XIX/XXI programs.

Exclude: Taxes associated with the Health Insurer Fee.

3.06 Footnote Disclosure Requirements

Footnote disclosures are required in order to supplement AHCCCS' understanding of the financial statements and supplemental schedules. The following list represents minimum expected disclosures and is not intended to be all-inclusive. Disclosures required by GAAP should also be included. If the disclosure does not apply, indicate so by writing "None" or "Not Applicable (N/A)" next to the numbered footnote.

1) Organizational Structure:

Discuss the organization structure, location of its headquarters, and a brief summary of the operations of the Contractor.

2) Summary of Significant Accounting Policies:

Discuss accounting policies relating to significant balance sheet line items such as, but not limited to, cash and cash equivalents, investments and methodologies used for BH (Title XIX/XXI and Non-Title XIX/XXI) and PH medical claims payable.

On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by program. Include the encounter timeframe used to allocate expenses.

Discuss revenue and expense recognition policies for the following:

- Capitation revenue, Non-Title XIX/XXI Revenue and Reconciliation Settlements

- Reinsurance revenue
- Other revenue
- Medical expenses
- Administrative Expenses
- Value Based Purchasing Initiatives
- Health Insurer Fee
- Taxes

Discuss any changes in accounting methodologies which have taken place during the current contract year.

3) Other Amounts:

Describe material amounts included in the "other" and "miscellaneous" categories in the Balance Sheet and Statement of Activities. Material amounts are considered greater than 10% of the related total category (i.e., assets, liabilities, revenues, total other medical expenses or administrative expenses).

4) Pledges/Assignments and Guarantees:

Describe any pledges, assignments, or collateralized assets and any guaranteed liabilities not disclosed on the balance sheet.

5) Performance Bond:

Disclose the method by which the Contractor satisfied the AHCCCS performance bond requirement. This disclosure is required whether or not the amounts are included in the financial statements.

6) Material Adjustments:

Disclose and describe any material adjustments made during the current reporting period. Include those adjustments that may relate to a prior period, specifically IBNR adjustments, that affect the financial statements and provide details for which period(s) the adjustment(s) relates.

7) Medical Claims Payable Analysis:

Explain large fluctuations and/or revisions in estimates and the factors that contributed to the change in the Medical Claims Payable balances from the prior quarter. Specifically, address changes of greater than +/-5% of the Total Liabilities for that quarter or the previous quarter if the amount is equal to or greater than +/-5%). Explanations should detail the amount of the adjustments by quarter and by category (PH and BH). For PH, disclose by hospital, medical comp, other and PPC)

8) Contingent Liabilities:

Provide details of any malpractice or other claims asserted against the Contractor, as well as the status of the case, potential financial exposure and expected resolution.

9) Investments (Current and Non-Current):
Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculations of the current ratio, must be disclosed in the footnotes. Descriptions and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20%) Also disclose the amount of Unrealized Gains or Losses reported on the financial statements associated with these investments.

10) Due from/to Affiliates (Current and Non-Current):
Describe, in detail, the composition of the due to/from affiliates including the name of the affiliate, a description of the affiliation, amount due to/from the affiliate and a description of any significant changes to the line item.

11) Equity Activity:

Disclose all activity in equity, other than net income or net loss.

12) Non-Compliance with Financial Viability Standards and Performance Guidelines:

Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve the issue(s), including specifying the expected month that the compliance will be evidenced in the Financial Statements.

13) Changes in Financial Statement Line Items:

Balance Sheet
Describe changes in balance sheet asset items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Assets for that quarter **and** if the change from the prior quarter amount is equal to or greater than +/-5%.

Describe changes in balance sheet liability line items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Liabilities (for that quarter **and** if the change from the prior quarter is equal to or greater than +/-5%.

Describe changes in balance sheet Equity/Net Assets line items if the current or previous quarter amount is equal to or greater than +/-5% of the Equity/Net Assets for that quarter **and** if the change from the prior quarter amount is equal to or greater than +/- 5%.

Balance Sheet changes should be calculated on a dollar basis. It is only necessary to describe changes impacting Medical Claims Payable in footnote #7.

Title XIX/XXI and Non-Title XIX/XXI Statement of Activities Summaries

Using the Title XIX/XXI and Non-Title XIX/XXI Statement of Activities Summaries, describe changes in the Statement of Activities if the current or previous quarter amount is equal to or greater than +/-5% of Total Revenues **and** if the change from the prior quarter amount is equal to or greater than +/-5%.

For Revenue and Administrative Expenses, describe changes by **individual line item**.

The percentage change quarter over quarter for the Statement of Activities medical expense line items should be calculated using **categorical subtotals** (i.e., treatment services, rehabilitation services, medical services, support services, crisis services, inpatient services, residential services, behavioral health day program, prevention, pharmacy, other services, BH FQHC/RHC, specialty and other grants, reinsurance, third party liability, Hospitalization, Medical Compensation, and Other Medical Expenses) for Title XIX/XXI and Non-Title XIX/XXI. Provide the calculation for the quarter over quarter change by category and identify the primary medical expense drivers by individual expense line items. If the primary driver is related to specific population(s), include that information in the explanation.

The first quarter in a Contractor's fiscal year should be compared to the fourth quarter in the previous fiscal year versus the final audit report.

When calculating the categorical amount as a percent of Total Revenue use whole dollars.

14) Pharmacy Rebates/Discounts

Provide the amount of pharmacy rebates or discounts received that the Contractor has recorded for the reporting period (line 417). Indicate whether or not the pharmacy rebates are either included in or excluded from the Lag Report for Medical Claims Payable.

Also, provide a written statement confirming that rebates do not include restricted drugs that are listed in the AHCCCS Rebate program.

15) Interest on Late Claims

Report interest payments made to providers on late claims. This amount should tie to the interest as reported in the Claims Dashboard for the same reporting period.

16) Accrued Sanctions

Report any accrued sanctions assessed by AHCCCS, the year-to-date amount of the accrual and the Statement of Activities line item in which they are included.

17) Provider Incentives

Report the amount of provider incentives reported for the period. Indicate the Income Statement line number and program in the financial statements where these are reported.

18) Value Based Purchasing

Report the amounts of any value based purchasing arrangements included in the financial statements.

19) Non-Covered Services

Report the type and amount of any non-covered service included in the financial statements. Indicate the line number and programs in the financial statements where these are reported.

20) Reinsurance

Provide the following general information: contracted vendor, deductible level and coinsurance. Also provide the following information quarterly: As of date, there was a Reinsurance Recovery of $XXXX and a receivable of $XXXXX recorded for reinsurance.

21) Prior Contract Year /Period Adjustments

Provide the amount reported on the Prior Contract Year Adjustments Schedule related to a prior contract year(s) and a detailed explanation for the adjustment(s).

Disclose and describe any material prior period adjustment(s) which is equal to or greater than 10% of total revenues or total expenses and is related to a prior quarter within the current contract year.

22) Marketing Cost

Include the amount reported on Management Fees (line 448) that is specifically related to marketing costs as delineated in ACOM Policy 404.

23) Block Grants

For SABG, insert a table by allocation category to show how much was expended on a **state fiscal year-to-date basis, July 1 – June 30.**

For MHBG EBP, footnote the total amount of **actual** expense (service and administrative) by category as per the Contractors approved plan on **state fiscal year-to-date basis, July 1 – June 30**. Indicate the type of expense and whether the Contractor is on track to fully expend the funds.

Provide sufficient details explaining why no funds have been expended or if the Contractor is experiencing barriers to spending these EBP funds.

Provide explanations for under/over expending in each block grant category compared to the SABG and the MHBG SED and SMI annual allocations by category. Indicate whether a re-allocation request will be submitted and when. Refer to 5.09 for additional information.

24) Premium Deficiency Reserve

Include the cumulative amount of the reserve as well as the current quarter amount and all line items included in the current quarter entry.

25) Additional Expense Explanations Requested by AHCCCS

Use this footnote to disclose additional information as requested by AHCCCS during the contract year.

a. GMH/SA Duals and CRS Crisis expenses are reported together with GMH/SA Non-Duals Crisis expenses in a single column. Separately identify the crisis amount related to GMH/SA Duals and CRS.
b. Disclose the total amount of County dollars expended on children. Of that amount, how much was expended on remanded juveniles by expense type.
c. Disclose the amount expended on incarcerated adults and children justice programs by Non-Title XIX/XXI funding.

4.00 SUPPLEMENTAL REPORTS

See Appendix E for examples of supplemental reports.

4.01 Financial Ratios

This report is for analysis purposes. Update the fields in red font.

4.02 Capitation and Non-Title XIX/XXI Funding Receivables

List the amounts that are included in the Balance Sheet – A/C 115. Amounts related to Capitation and Non-Title XIX/XXI should be detailed out by program and contract year or state fiscal year.

4.03 Receivables/Payables Report

List the amounts, by type, that are included in the Balance Sheet – A/C 122 and A/C 222. Amounts related to PCP Parity reconciliations/cost settlements (both receivables and payables where applicable) should be detailed by contract year.

4.03.1 Payable to Providers Report

The Contractor shall promptly contract and distribute funds to subcontracted providers to avoid a build-up of payables toward the final quarters of the contract year. AHCCCS will monitor the flow of service dollars from the Contractor to its subcontracted providers to ensure service dollars are getting to the provider community timely so they can be appropriately encountered.

AHCCCS reserves the right to request additional detailed information regarding the subcontracted provider payables, payouts and reversal of accruals, as necessary.

A Payable to AHCCCS liability should be recorded for all non-contracted service funds received by the Contractor from AHCCCS but not distributed to providers. This excludes Medical Claims Payable, Value Based Purchasing and payment timing delays. A Payable to Provider liability should be recorded for all contracted funds due to providers.

The Contractor shall not retain excess provider payable amounts that are not assigned by provider to pay out to providers after the contract year end. Funds may be recouped from under-performing providers and paid to providers who have over-encountered and are exceeding performance expectations. An Analysis/Itemization of Provider Payables by fiscal year, provider, contract type, amount, funding category and description must be submitted quarterly as a part of the Financial Reporting Package.

The Payable to Providers Report should tie to the BH Payable line under A/C 215.

4.04 Other Assets Report

Include all other assets (current and non-current) in the appropriate categories provided. List all individual assets greater than 10% of total other assets separately and list the total of others not individually greater than 10%. The ending balances for current assets should agree to A/C 140 and non-current assets to A/C 165 of the Balance Sheet.

4.05 Other Liabilities Report

Include all other liabilities (current and non-current) in the appropriate categories provided. List all Value Based Purchasing Initiative amounts and individual liabilities greater than 10% of total other liabilities separately, and list the total of others not individually greater than 10%. The ending balances for current liabilities should agree to A/C 240 and non-current liabilities to A/C 255 of the Balance Sheet.

4.06 Value Based Purchasing Payables to Providers

List the amounts that are included in the Balance Sheet – A/C 135 and A/C 225 and A/C 255. Information should be detailed by provider and by contract year.

4.07 BH Title XIX/XXI, BH Non-Title XIX/XXI and PH Lag Reports

Lag Reports are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. If the Lag Report is not the primary methodology, the Contractor should use lag information as a validation test for accruals calculated using other methods. The instructions below apply to all Lag Schedules.

Each schedule is arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter are reported on row 1, column 2, while payments made during the current quarter for services rendered in prior quarters are reported on row 1, columns 3 through 8. Do not include sub-capitation and block payments in this schedule.

Title XIX/XXI BH expenses reported in the current period on the Title XIX/XXI BH Lag Report should equal the Title XIX/XXI BH expenses reported in the Statement of Activities less the Title XIX/XXI BH expenses reported in the sub-capitated expense and block payment reports in total and less amounts reported under account 511 for BH VBP expenses.

Non-Title XIX/XXI BH expenses reported in the current period on the Non-Title XIX/XXI BH Lag Report should equal the Non-Title XIX/XXI BH expenses reported in the Statement of Activities less the Non-Title XIX/XXI BH expenses reported in the sub-capitated expense and block payment reports in total.

PH expenses reported in the current period on the Lag Report should equal the PH expenses reported in the Statement of Activities less the PH expenses reported in the sub-capitated expense and block payment reports by hospital, medical compensation, and other in total and less account 434, Value Based Purchasing Provider Expenses.

The schedule allows for the inclusion of an adjustment (e.g., for provider refunds, lag schedule adjustments) amount to the lag schedule. A general explanation of any adjustments should be included in the footnotes as well as additional detail if any adjustment is greater than 10% of total medical claims payable.

A separate Lag Report should be prepared for BH Title XIX/XXI, BH Non-Title XIX/XXI and PH. The Remaining Balance on all Lag Reports combined should agree to the Medical Claims Payable total as reported on the Balance Sheet.

4.08 Long-term Debt (Other than Affiliates) Report

List all loans, notes payable and capital lease obligations by lender as well as by current and long-term portions of outstanding principle at the end of the quarter (exclude debt to affiliates, this is to be reported on the Due (to) from Affiliates line). The totals should equal the amounts reported on the Balance Sheet – A/C's 230 and 245.

4.09 Reserved for Future Use

4.10 BH and PH Sub-capitated Expense Reports

This report is a summary of sub-capitation expenses, by Title XIX/XXI program, by individual expense line item. Only list the accounts in this report that have sub-capitation expenses. Sub-capitated expenses SHOULD NOT be reported for Account 434, Value Based Purchasing Provider Expenses and Account 511 for BH VBP expenses. This information assists in calculating any reconciliation and is used in capitation rate setting. Effective for all Contractors with fiscal years ending on or subsequent to September 30, 2016, an Independent Auditor's Attestation is required for the BH and PH sub-capitated expenses report as a part of the annual audit.

Exclude from sub-capitation expense, PCP Parity Enhanced Payments as reported under Account 415. For example if the payment to a sub-capitated Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported on the Sub-capitated expense report is $15.

4.11 BH and PH Block Purchases Expense Report

This report is a summary of block purchases expenses, by Title XIX/XXI program, by individual expense line item. Only list amounts in this report for expenses that have block purchasing arrangements.

Block purchase expenses SHOULD NOT be reported for Account 434, Value Based Purchasing Provider Expenses and Account 511 for BH VBP expenses. This information assists in calculating any reconciliation and is used in capitation rate setting.

Exclude from block purchases expense, PCP Parity Enhanced Payments as reported under Account 415. For example if the block purchase payment to a Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported on the block purchases expense report is $15.

Effective for all Contractors with fiscal years ending on or subsequent to September 30, 2016, an Independent Auditor's Attestation is required for the BH and PH Block purchases expenses report.

4.12 Prior Contract Year Adjustment Schedules

This report is intended to be a summary of material adjustments that apply to prior contract years. Please list all balance sheet and income statement adjustments on the appropriate line. All IBNR adjustments need to be broken out by AHCCCS contract year on this schedule. All other material adjustments need to be broken out if a financial statement line that is greater than 10% of total assets (for all assets), total liabilities (for all liabilities), or total revenue (for all revenue and expenses) and the change is greater than 10% over the previous quarter. The adjustments need to be broken out between the current AHCCCS contract year and previous AHCCCS contract years.

4.13 FQHC/RHC Member Months

Effective 04/01/2015, AHCCCS and its contracted Managed Care Organizations (MCOs)began paying the all-inclusive per visit PPS rate on a per claim basis, replacing the previous method of reimbursing claims by the capped fee-for-service fee schedule and annually reconciling to the PPS rate. The method for calculating the all-inclusive per visit PPS rates did not change.

For dates of services on or after April 1, 2015, procedure code T1015 should be used for reporting physical health, behavioral health and dental visits for purposes of reimbursing PPS-eligible visits.

A claim for an FQHC, FQHC-LA or RHC visit must include all appropriate procedure codes describing the services rendered in addition to visit code T1015. A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at $0.00.

BH FQHC/RHC expenses should be reported on line number 512 of the Statement of Activities, and PH FQHC/RHC expenses on line 411.

Contractors are required to report member month information by risk group for each FQHC/RHC where a SMI PCP assignment has been made for physical health.

Any member assigned to the FQHC/RHC on the first day of the month should be counted as one member month. Partial months will not be counted. Exclude State only transplant member months. Please ensure to use the most current schedule Appendix E-9. This report is due to AHCCCS 60 days after the quarter.

Contractors are responsible for maintaining a detailed listing, by month, of members receiving services. This listing should include member name, AHCCCS ID number, primary care physician, Provider Type Code, FQHC/RHC assigned, FQHC/RHC AHCCCS Provider ID, rate code at date of service and amounts paid. The listing does not need to be submitted with the quarterly FQHC/RHC Report. It should be maintained internally and provided upon request.

The rate code on the 834 AHCCCS eligibility loop should be used to identify the categories for reporting. Refer to Rate Codes To Be Included in Main Risk Groups Report using the following link:
https://www.azahcccs.gov/PlansProviders/Downloads/CapitationRates/RiskPooltoEligibilityCategorytoRateCode.pdf

4.14 Consolidated or Parent Company Financial Statements (if applicable)

AHCCCS reserves the right to require contactors that are a wholly owned subsidiary of another organization to submit quarterly unaudited financial information of the parent or sponsoring organization (balance sheet and statement of activities only).

4.15 Related Party Transaction Reports

Related Party Transaction statements must be submitted to AHCCCS 120 days after contract year-end. See the AHCCCS website for the template for this report:
(https://www.azahcccs.gov/Resources/Contractor/Manuals/financialReporting.html)

4.16 Annual Financial Reporting

In addition to the annual audited financial statements, a reconciliation of the Contractor's final year-to-date quarterly financial statements to the draft annual audited statements must be submitted with the draft audited statements. This reconciliation schedule must also be submitted with the final audited statements. No new account classifications should be added, see your Financial Consultant for technical assistance.

Any footnotes or supplemental schedules that are impacted by draft or final audit adjustments must be resubmitted to agree to the audited amounts in the draft and final audit and resubmitted with these reports. See Appendix F for an example of the annual audit reconciliation report.

The Draft and Final Audited Financial Statements should also include an annual Statement of Activities and Schedule A Disclosure audited by program. In addition, the Audited Financial Package should also include a Single Audit.

4.17 Parent Company Annual Audit Report (if applicable)

AHCCCS reserves the right to require Contractors that are wholly owned subsidiaries to submit audited financial statements of the parent or sponsoring organization no later than 120 days after the parent company's fiscal year end.

5.00 ACCOUNTING AND REPORTING ISSUES

5.01 Medical Claims Liability (Including Claim Estimations RBUCs and IBNRs)

There are three primary components of claims expense:

- Paid claims,
- Received but unpaid claims (RBUCs). A claim is considered an RBUC immediately upon receipt by the Contractor and should be tracked as such. The processing status of an RBUC is either pended, in process or payable, and
- Incurred but not reported claims (IBNRs).

The first two components of claims expense are readily identifiable as part of the basic accounting systems utilized by the Contractors. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important that Contractors have adequate claims accrual and payment systems. These systems must be capable of reporting claims on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that the Contractors continually monitor them with reference to paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered:

- Changes in policy, practice, or coverage
- Fluctuations in enrollment by BH categories/rate code category
- Expected inflationary trends
- Trends in claims lag time
- Trends in the length of hospital inpatient stay by BH categories/rate code category
- Changes in BH categories/rate code case mix
- Changes in contractual agreements

<u>Elements of an IBNR System</u>

IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred by AHCCCS Contractors, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and a logical IBNR methodology are required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a Contractor's own circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis, usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. Also, the Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to the Contractor's members.

2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a proforma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., paid claims).

3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). Prior authorization data, together with claims data and other relevant information, should be used to identify claims liabilities.

4. Claims data should also be segregated to permit analysis by behavioral health/major rate code, county, major provider, and category of service.

5. Subcontract agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood, and followed consistently by each party.

6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a Contractor's IBNR methodology if applicable.

There are several different methods that may be used to determine the IBNR amount. Examples include, but are not limited to, Case Basis, Average Cost and Lag Tables (see below). The Contractor should employ the one that best meets its needs and accurately estimates its IBNR. The IBNR methodology used by the Contractor must be evaluated by their Independent Certified Public Accountant or Actuary for reasonableness.

A description of the methodology to determine BH and PH IBNR should also be included in the footnotes to the financial statements under Footnote #2.

Case Basis Method

Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost can be made after the services have been authorized by the Contractor. For example, if a Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

Average Cost Method

As the name suggests, average costs of services are used to estimate total expense. The expenses estimated using average costs are then reduced by claims that have been paid or claims that have been received but are unpaid (RBUCs). There are two primary average cost methods which are discussed below. It is important to note that each method may be used by a Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. all other medical).

Per Member Per Month (PMPM) Averages

Under this method the average costs are based on the population rate for each risk group over a given time period. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid and RBUCs for the service category are subtracted from the expense estimate which results in the IBNR liability estimate for that service category.

Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get to the IBNR liability. This method is primarily used for hospitalization IBNRs as Contractors generally know the number of hospital days authorized at any given time.

5.02 Reinsurance

Reinsurance provides reimbursement to the Contractors when extraordinary costs associated with a member are incurred during a contract year. Reinsurance receivable should include all expected reinsurance from contracted vendor, billed and unbilled.

5.03 Related Parties/Affiliates

AHCCCS monitors the existence of related party transactions in order to determine if any significant conflicts of interest exist in the Contractor's ability to meet AHCCCS objectives. A related party or affiliate may be defined as anyone who has the power to control or significantly influence the Contractor or be controlled or significantly influenced by the Contractor. Accordingly, subsidiaries, parent companies, sister companies, and entities accounted for by the equity method are considered related parties, as are principal owners, Board of Director members, management, and their immediate families, and other entities controlled or managed by any of the previously listed entities or persons, including management companies. Related party transactions include all transactions between the Contractor and such related parties, regardless of whether they are conducted in an arm's length manner or are not reflected in the accounting records (e.g., the provision of services without charge or guarantees of outstanding debt).

Transactions with related parties may or may not be in the normal course of business. In the normal course of business, there may be numerous routine and recurring transactions with parties who meet the definition of a related party. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed and reviewed for reasonableness.

5.04 Financial Viability Standards and Performance Guidelines

The Contractor must comply with the AHCCCS-established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios and performance guidelines with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Title XIX/XXI Member; Contract Year to Date Title XIX/XXI Medical Expense Ratio; Contract Year to Date Non-Title XIX/XXI Medical Expense Ratio; Contract Year to Date Title XIX/XXI Administrative Cost Percentage; Contract Year to Date Non-Title XIX/XXI Administrative Cost Percentage; Maintenance of Minimum Capitalization and Performance Bond.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. If a critical combination of the Financial Viability Standards is not met, or if the Contractor’s experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

Title XIX/XXI includes the following programs: Non CMDP Child, CMDP Child, DD Child, GMH/SA Non Dual, DD Adult, SMI Integrated and SMI Non-Integrated.

Non-Title XIX/XXI includes the following programs: Crisis, SMI, Supported Housing, SB1616 Housing, MHBG SED, MHBG SMI, SABG, Other Federal, County and Other.

FINANCIAL VIABILITY STANDARDS

Current Ratio

Current assets divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%).

Standard: At least 1.00

If current assets include a receivable from a parent or affiliated company, the parent or affiliated company must have liquid assets that support the amount of the intercompany loan. Other Assets deemed restricted by AHCCCS are excluded from this ratio.

Equity per Title XIX/XXI Member

Unrestricted equity, less on-balance sheet performance bond, divided by the number of members eligible/enrolled at the end of the period. For this calculation use members as reported on the first day of the month following the end of the quarter (i.e. for quarter ending March 31, xx use April 1st enrollment) at the following link for SMI Integrated:
https://www.azahcccs.gov/Resources/Reports/providerpopreport.html
Use report titled Enrollment by Health Plan by County.

Use eligibility counts from the Enrollment Penetration Report or its successor for Non-Integrated at the following link:
https://www.azahcccs.gov/Resources/Reports/behaviorhealth.html
The information above can also be found on the BHS Weekly 820 files using the monthly payment (do not include the daily member month amounts).

Standard: At least $25 per Title XIX/XXI member assigned to the Contractor eligible to receive behavioral health services only, and $25 per Title XIX/XXI member enrolled with the Contractor for integrated SMI services

Additional information regarding the Equity per Title XIX/XXI Member requirement may be found in ACOM 305.

Contract YTD Title XIX/XXI Medical Expense Ratio

The sum of Subtotal BH Medical Expenses + Total PH Medical Expenses divided by the sum of total PPC and Prospective capitation (lines #305 & #310) + Title XIX/XXI Reconciliation (line #319) + PCP Parity Cost Settlement (line #323) – Premium Tax

Standard: At least 85%
When calculated on a contract year-to-date basis

State Fiscal YTD Non-Title XIX/XXI Medical Expense Ratio	Non-Title XIX/XXI Subtotal BH Medical Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #311) + Non-Title XIX/XXI Profit Limit (lines #320) + Non-Title XIX/XXI General Fund Profit (line #321) *Standard: At least 88.3%* ***When calculated on a state fiscal year-to-date basis***
Contract YTD Title XIX/XXI Administrative Cost Percentage	Title XIX/XXI Subtotal Administrative Expenses divided by the sum of total PPC + Prospective Capitation (lines #305 & #310) + Title XIX/XXI Reconciliation (line #319) + PCP Parity Cost Settlement (line #323) - Premium Tax *Standard: No more than 10%* ***When calculated on a contract year-to-date basis***
State fiscal YTD Non-Title XIX/XXI Administrative Cost Percentage	Non-Title XIX/XXI Subtotal Administrative Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #311) + Non-Title XIX/XXI Profit Limit (line #320) + Non-Title XIX/XXI General Fund Profit (line #321) *Standard: No more than 8%* ***When calculated on a state fiscal year-to-date basis***
Maintenance of Minimum Capitalization	Net assets (not including the value of the on-Balance Sheet Performance Bond and Other Assets deemed restricted by AHCCCS) shall be greater than or equal to ninety percent (90%) of the monthly Title XIX/XXI capitation and Non-Title XIX/XXI payment to the Contractor.
Performance Bond	Performance Bond shall be one hundred percent (100%) for Greater Arizona Contractors (eighty percent (80%) for Maricopa Contractor) of the monthly Title XIX/XXI capitation and Non-Title XIX/XXI payment to Contractor. Refer to ACOM 305 for additional information.

5.05 Block Payment Arrangements

AHCCCS reserves the right to limit the Contractor's percentage of block payment arrangements with its subcontractors.

5.06 State General Funds

State General Funds are appropriated by legislature and must be expended (based on dates of service) by June 30 of each state fiscal year at both the Contractor and provider

levels. These funds are noted as State General Funds in the AHCCCS Allocation Schedule.

The Contractor is expected to monitor provider expenditures to ensure that State General Funds are spent by June 30. In general, expend State General Funds before County funds. Grant funding should be the payer of last resort. Certain exceptions may be allowed. The Contractor and its providers are not allowed to defer State General Funds; and shall provide AHCCCS with projected unexpended State General dollars by fund source via email or letter by March 31 of each state fiscal year. The Contractor should also include projected unexpended County and Block Grant funding in this report.

Providers must return unexpended State General Funds to the Contractor; and subsequently, the Contractor must return the funds to AHCCCS upon request.

Unexpended funds held by the Contractor and/or Contractor providers may be withheld from future payments by AHCCCS or must be returned to AHCCCS upon request.

The Contractor shall add this requirement to their provider contracts, provider financial reporting guides or otherwise communicate this requirement to providers.

5.07 Non-Title Crisis, SMI and Housing

The Contractor shall expend a minimum of 92.0% of State Funds on services and administrative expenses are limited to 8.0% for Non-Title XIX/XXI Crisis, Non-Title XIX/XXI SMI, Supported Housing and SB1616 Housing. Contractors may expend administrative funding on service expenses but may not expend service funding on administrative expenses. If the 92% Medical Expense Ratio is not met, the Contractor must return the difference between the medical expenses and 92% of total revenue. State Funds not expended on services and administration must be returned to AHCCCS. Throughout the contract year, the Contractor shall accrue a payable for estimated profit in Non-Title XIX/XXI Crisis, Non-Title XIX/XXI SMI, Supported Housing and SB1616 Housing and report the amount in the Statement of Activities on A/C 321. For additional information, refer to ACOM 323.

Funds allocated for Supported Housing, SB1616 Housing, Bridge Subsidy and Non-Title XIX/XXI SMI Supported Housing must be spent in accordance with approved housing plans. Approval must be obtained from AHCCCS prior to deviating from approved plans. Should these funds have been expended for any purpose other than that outlined in the current year approved housing plan, these expenditures will need to be re-classified to a Non AHCCCS funding source or net assets as appropriate. Housing expenditures, with the exception of Bridge Subsidy, should be reported on the Statement of Activities, under the applicable program on line 504g and disclosed on the Statement of Activities, Schedule A Disclosure accordingly using the drop down menu.

5.08 Encounter Reporting Requirements

The Contractor is required to submit encounters or claims for every service rendered to a member in accordance with encounter and claims submission requirements outlined in AHCCCS Guides and Manuals.
Accurate encounter data shall be submitted timely to assist AHCCCS in evaluating the Contractor's performance and for establishing capitation rates. For a complete list of service codes by provider type refer to the AHCCCS Covered Services Guide, Appendix B-2. Annual encounter reporting analysis shall be performed regularly by AHCCCS no sooner than 8 months after the end of the contract year.

The Contractor must develop statistically sound encounter rates. The value used by Contractor subcontractors to encounter services shall be determined by the contracted rate established at the beginning of the contract year.

Any retrospective changes, to contracted rates that may result in the adjustment or voiding and replacement of encounters must be pre-approved by AHCCCS as specified by Contract. For details regarding recoupments or reprocessing of FFS claims, refer to the ACOM 412.

Encounter Evaluation Report
AHCCCS shall, at least annually, calculate the Contract Year value of encounters (based on dates of service) submitted by the Contractor. The calculation will be performed in order to measure timeliness and completeness of encounter submissions. For purposes of the Encounter Evaluation Report, encounter reporting as submitted to AHCCCS may be considered complete when the Contractor's accepted/approved encounter values reach the minimum percentage levels specified in the table below as compared to the service (non-administrative) revenue (92.0% of total AHCCCS revenue) for each evaluation period. Service revenue will include profit limit revenue adjustments. Revenue not required by AHCCCS to be encountered will be excluded from the encounter reporting calculation (also known as encounter relief).

Non-Title XIX/XXI Annual Encounter Evaluation Sanction
The Contractor will have eight (8) months following the end of the contract year to meet the required contractual requirement of 85%. AHCCCS shall have the discretion to assess sanctions on Non-Title XIX/XXI if the Contractor fails to meet the annual required encounter percentage.

For the Non-Title XIX/XXI annual encounter evaluation sanction, whether assessed by AHCCCS or accrued by the Contractor, the entire sanction shall be reported on the Statement of Activities, line 459, Encounter Evaluation Sanctions, under the program(s) applicable to the sanction and disclosed on the Contractor Statement of Activities, Schedule A Disclosure. Recoupment of this sanction from providers should also be reported on line 459 and disclosed on a separate line in the Statement of Activities, Schedule A Disclosure as an offset to this sanction.

Block Payment Provider Encounter Monitoring

The Contractor shall define block payment provider encountering expectations and recoupment processes in provider contracts and/or the Contractor Financial Reporting Guide. The Contractor is expected to hold their block payment providers to the block payment provider contractual provisions and established expectations for encountering services.

When monitoring block payment provider encounters and evaluating for funding recoupment and re-allocation, the Contractor should at a minimum consider encounter values, block payment provider performance and block payment provider profit levels.

Annually, AHCCCS will request evidence that a Contractor regularly monitors the volume of encounters submitted by their block payment providers. The report will include the following:

A. Total Revenue Paid to each block payment provider by individual program (funding source)
B. Total Encounter Value submitted by each block payment provider by individual program (funding source)
C. Percentage of letter B (above) divided by letter A (above)
D. Audited block payment provider profit in dollars and percentage
E. Contractor Encounter Submission Standard
F. Explanation for under/over production of encounters by block payment provider by funding source. Also, describe the efforts made by the Contractor to address problems related to block payment provider under/over encountering
G. Amount the Contractor has recouped or will recoup from block payment providers for under-encountering by individual program or funding source. List total recoupment from each block payment provider and include the month/year of recoupment whether planned or completed. If no funding will be recouped, explain why.
H. If applicable, list overall barriers to encountering, summarized by Title XIX/XXI and Non-Title XIX/XXI, experienced by the block payment providers during the contract year.

AHCCCS reserves the right to require the Contractor to limit block payment provider's profit and administrative percent.

5.09 Block Grants

The practices, procedures and standards specified in and required by the State of Arizona Accounting Manual and any Uniform Financial Reporting Requirements shall be used by the Contractor in the management, recording and reporting of Federal Block Grant funds. The Contractor shall establish fiscal controls to ensure that funds are accounted for in a manner that permits separate reporting of mental health and substance abuse grant funds and services. SABG and MHBG funds should be allocated and

monitored in accordance with the AHCCCS' Allocation Schedule or Payment Report, whichever is the most current.

Prior written approval must be obtained from AHCCCS for any deviations from the AHCCCS Allocation Schedule or Payment Report, whichever is the most current. Funds paid to the Contractor for a state fiscal year shall be available for obligation and expenditures until the end of the state fiscal year for which the funds were paid. Similarly, funds paid to the Contractor for a contract year shall be available for obligation and expenditures until the end of the contract year for which funds were paid.

By March 31, the Contractor shall, notify AHCCCS of all Federal Block Grant funds projected to be unexpended by June 30. With AHCCCS' approval, the unexpended revenue may be expended after June 30 and reported in the same program as AHCCCS originally remitted or will be recouped by AHCCCS.

The Contractor shall comply with all terms, conditions and requirements of the SABG and MHBG. Financial, performance and program data subject to audit shall be retained by the Contractor as documentation of compliance with federal requirements. SABG and MHBG financial monitoring should encompass the following:

- Maintain policies and procedures that outline internal monitoring of federal block grant requirements.
- Notify providers of required subaward information as required by 2 CFR Part 200.
- Notify to providers of Single Audit submission requirements. Non-Federal entities that expend $750,000 or more in a year in federal awards shall have a Single Audit conducted for that year in accordance with 2 CFR Part 200 Subpart F.
- Maintain tracking tool to monitor receipt of Single Audits. At a minimum, the tool should contain the following information: Provider Name, Audit Received Date, Management Decision Letter Date, Audit Findings (Y/N) and Date Response/Corrective Action Plan Received.
- Issue management decision for audit findings as required by §200.521 Management decision.
- Communicate prohibited uses of SABG and MHBG funds to providers.
- Track grant funds, including unexpended funds, for appropriate allocation by category, recoupment and/or return to AHCCCS.
- Monitor grant activities to ensure SABG and MHBG funds are expended for authorized purposes.
- Any Additional requirements of 2 CFR Part 200 Subpart F.

Compliance with 2 CFR Part 200 Subpart F shall be incorporated into provider contracts. In addition, the Contractor should require their contracted block grant providers to have internal policies and procedures related to SABG and MHBG. The policy and procedure should include, but are not limited to, a listing of prohibited expenditures, references to the

SABG and MHBG FAQs, monitoring and reporting of funds by priority populations and funding category. As per contract or upon request, the Contractor is required to submit SABG and MHBG information for Federal Reporting purposes in the manner and format provided by AHCCCS.

5.10 Cost Allocation Plan

The Contractor shall prepare an indirect cost allocation plan in conformance with appropriate federal regulations such as 2 CFR Part 200 Subpart E Cost Principles for Non-Profit Organizations. The cost principles described in 2 CFR Part 200 Subpart E will be the standard applied to Cost Allocation Plans submitted by the Contractor including for-profit entities. A list of individual costs to be allocated, along with the applicable base should be included in all Cost Allocation Plans. As per the 2 CFR Part 200 Subpart E, actual conditions shall be taken into account in selecting the base to be used in allocating the expenses in each grouping to benefiting functions. The essential consideration in selecting a method or a base is that it is the one best suited for assigning the pool of costs to cost objectives in accordance with benefits derived; a traceable cause and effect relationship; or logic and reason. When an allocation can be made by assignment of a cost grouping directly to the function benefited, the allocation shall be made in that manner. In accordance with 2 CFR Part 200 Subpart E, expenses should be recorded directly to the applicable program(s), if identifiable. If the program(s) cannot be readily identified, pro-rate the expense using the percentage of AHCCCS medical expense for each program. The use of revenue as the base for the allocation of all allowable general and administrative cost including corporate overhead is not acceptable. Revenue is not an equitable base for allocation because it has no relationship to cost nor does it have a relationship to the provision of services. This plan shall be submitted to AHCCCS for approval by August 1 of each contract year and should identify items of cost and its allocation base.

The Statement of Activities shall be reviewed by the Contractor's Auditor for adherence to the Contractor's cost allocation plan and shall be an integral part of the Contractor's annual certified audit. Any issues of non-compliance with federal guidelines must be included in the certified audit report. All instances of questioned costs or procedural deficiencies related to Indirect Cost Plans, as identified in the certified audit reports, will be investigated by AHCCCS, and are subject to repayment to AHCCCS.

5.11 Community Reinvestment

Community Reinvestment expense should be reported on the Statement of Activities Line 610, Profit/(Loss) from Other, Non-AHCCCS and Non-Operating, under the Mgmt & Gen Column and disclosed on the Statement of Activities, Schedule A Disclosure. Report the liability and disclose by year on the Other Liabilities Report. The Contractor shall submit an annual Community Reinvestment Report to AHCCCS by March 31 of each year (refer to Appendix J for template). If the reinvestment relates to a previous years' commitment, indicate this on the report under the Commitment Year Column. For Community Reinvestment requirements during the year of contract termination, refer to Paragraph 5.14.

5.12 Deferred Revenue

The Contractor is expected to regularly determine from their providers whether there will be unspent funds by the end of the contract year or state fiscal year in the case of general funds and block grant funds. If general funds remain at the end of the fiscal year, providers are prohibited from recording deferred revenue; instead, these unspent general funds must be reported as a Payable to the Contractor and returned to the Contractor immediately for subsequent return to AHCCCS. Title XIX/XXI, Grant and County revenue may be deferred at the end of the provider's fiscal year only under extenuating circumstances.

5.13 PCP Parity

Reimbursement requirements for enhanced payments apply to payments made for dates of service January 1, 2013 through December 31, 2014.

PCP Parity payments from AHCCCS should be reported on the Statement of Activities, line 323, PCP Parity Cost Settlement, under the applicable funding source. PCP Parity related expenses should be reported on the Statement of Activities, lines 408 or 415, as applicable. Only PCP Parity enhanced payment expenses should be reported on line 415.

Receivables and Payables related to PCP Parity should be treated in the same manner as other AHCCCS Receivables and Payables. Disclose accordingly on the Balance Sheet.

5.14 Contract Termination

In the year of contract terminations, AHCCCS reserves the right to restate any final reports, including Title XIX/XXI Reconciliations, Non-Title XIX/XXI Profit Limit Analysis and Encounter Evaluation, based on changes to revenue and expenses during the close-out period. The changes to revenue and expenses may result from, but are not limited to, prior period adjustments. The close-out period begins with contract termination and concludes when the Contractor has settled all contract related liabilities. The Contractor must continue to submit quarterly financial statements and other required reports by the established due dates and in the required format until all contract liabilities have been paid and all required deliverables have been accepted by AHCCCS. Sanctions may be assessed for late deliverables and for deliverables submitted in the incorrect format.

The Contractor shall maintain local staff that are familiar with the operational details of preparing the financial statements and other required financial reports for an agreed upon period following contract termination as pre-approved by AHCCCS. Unless otherwise specified by AHCCCS, a staffing plan specific to Finance shall be submitted to AHCCCS for pre-approval as a part of transition planning.

If applicable, this staffing plan should also clearly specify the role that the Contractor's corporate office will play, if any, during the termination period. An appropriate staffing plan is critical to ensuring that accurate reporting and deliverable timelines continue to be

met during the contract close-out period; thus potentially avoiding unnecessary sanctions related to late or incomplete deliverables.

For run-out purposes, the Contractor shall maintain a Performance Bond that has an expiration date of at least fifteen (15) months after the contract expiration date. If the Contractor has additional liabilities outstanding fifteen (15) months after the termination of the contract, the Contractor may request a reduction in the Performance Bond sufficient to cover all outstanding liabilities, subject to AHCCCS' approval, until all liabilities have been paid.

As a part of transition planning, the Contractor must also submit a Community Reinvestment Distribution Plan outlining how committed funds will be reinvested into the community after contract termination. Committed funds includes any non-invested funds remaining from previous contract years and especially funds related to net profit earned during the final contract year. Alternatively, the committed reinvestment funds can be returned to AHCCCS for reinvestment into the community.

5.15 Provider Audits

The Contractor shall submit electronically the most recent Annual Audited Financial Statements, including Single Audits if applicable, of their Top 20 Providers by May 31. Use AHCCCS Revenue to determine the Top 20 Providers.

When submitting the electronic versions of the audits, include a Summary Report listing the Top 20 Providers and the Amount Paid to them during the reporting period.

Contractors should not procure the audit firm(s) on behalf of providers. Contractors should also encourage providers to review the Sarbanes-Oxley Act and apply the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five years.

6.00 APPENDICES

Appendix A: Certification Statement
Appendix B: Financial Statement Reporting Template Audit Report
Appendix C: Financial Statements
Appendix D: Financial Statement Footnote Disclosures
Appendix E: Supplemental Reports
Appendix F: Audit Reconciliation Report
Appendix G: Related Party Transactions
Appendix H: Behavioral Health Covered Services Mapping Matrix
Appendix I: Physical Health Covered Services Mapping Matrix
Appendix J: Community Reinvestment Report

7.00 EXHIBITS

Exhibit 1: Sample Footnotes For Quarterly Financial Reports

Paragraph 3.06
Quarter ended MM/DD/YYYY
Footnotes

1. ORGANIZATIONAL STRUCTURE
Discuss the organization structure, location of its headquarters, and a brief summary of the operations of the Contractor.

Company ABC was established on October 1, 1982, as a division of Company XYZ Health Services Network, an Arizona not-for-profit corporation.

Company ABC is located at 123 Main Street in Phoenix, Arizona, and is contracted with AHCCCS to administer behavioral and physical health services on an integrated basis to Medicaid eligible adults determined to be Seriously Mentally Ill, and to operate as the Regional Behavioral Health Authority to coordinate the delivery of health care services to eligible persons in Marion and Lakewood counties.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *Discuss accounting policies relating to significant balance sheet line items such as, but not limited to, cash and cash equivalents, investments and methodologies used for BH (Title XIX/XXI and Non-Title XIX/XXI) and PH medical claims payable.*

On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by program. Include the encounter timeframe used to allocate expenses.

Discuss revenue and expense recognition policies for the following:

- *Capitation revenue, Non-Title XIX/XXI Revenue and Reconciliation Settlements*
- *Reinsurance revenue*
- *Other revenue*
- *Medical expenses*
- *Administrative Expenses*
- *Value Based Purchasing Initiatives*
- *Health Insurer Fee*
- *Taxes*

Discuss any changes in accounting methodologies which have taken place during the current contract year.

Cash and Cash Equivalents
Cash includes cash deposits in banks and cash equivalents. Company ABC considers all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents. Amounts at each institution are insured in limited amounts by the Federal Deposit Insurance Corporation (FDIC).

Short-term Investments
All short term investments can be converted to cash within 24 hours.

Reinsurance Receivable
Contractor reviews claims payments to determine claims that are eligible for reinsurance. These are reported on the financial statements in the amount expected to be collected from the contracted vendor.

Reconciliation/Settlement Receivable
Monthly, an amount estimated by program to be due to or due from AHCCCS is calculated and reported on the financial statements.

Investment Income Receivable
Income that is earned but not yet received is recognized in the month identified.

Other Current Assets
Current portion of fixed assets which are not captured elsewhere on the balance sheet. Any receivables from providers are accounted for on this line and are not netted against IBNRs.

Long Term Investments
$500,000 are restricted U.S. government securities held by a bank required to remain in trust by the State of Arizona, Department of Insurance for the duration of the contract with AHCCCS. This is related only to the Medicare Business.

Property, Plant and Equipment
Contractor has no Property, Plant, or Equipment.

Medical Claims Payable
BH and PH Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by an outside actuary. Further information regarding the calculation of IBNR balances can be found in the Contractor IBNR policy. All medical expenses payable are reported net of Medicare.

Received but Unpaid Claims (RBUC's)
Medical claims are logged into the Contractor's claim system when received. Any claims in the claims department that haven't been logged at quarter end are summarized. An estimated amount due for these received but unpaid/unprocessed claims is reported on the Medical Claims Payable report. Claims that have been processed but for which no check has been issued are also included as well as any unpaid pharmacy invoices for which an invoice has been received.

There are a number of PH claims for which the claim category (medical, hospital, other) is unknown. These claims are distributed among the different claim categories based on the total accrual for each category with adjustments made to this distribution as appropriate.

The RBUC lag for all unprocessed claims is based on the actual lag between date received and the end of the reporting period. The lag for unpaid pharmacy invoices and processed claims for which no check has been issued is assumed to be "current."

Methodology for allocating revenue and medical expenses to each program
Company ABC uses several sources of information for allocating the revenues and expenses on the Statement of Activities. For capitation revenue and member months, the BHS Weekly 820 files received from AHCCCS are utilized. The AHCCCS Allocation Schedule is used for Non-Title XIX/XXI Revenue.

Medical Expenses paid via block payment are allocated to the fund types (Title XIX/XXI Non CMDP Child, Title XIX SMI, etc.) based on the year-to-date block payments.

Within a fund type, the allocation by service line is based on the year-to-date encountered claims data. FFS expenses include both paid claims and estimated IBNR. IBNR is based on the historical experience that is available and is reviewed by the actuarial department. Pharmacy expenses are booked to the fund types based on actual pharmacy expenses paid year-to-date.

Non-encounterable services (SABG Prevention, SABG HIV, Bridge Subsidy Housing grant) are directly allocated based on actual and estimated expenses incurred year-to-date.

For hospital expenses Company ABC utilizes a combination of paid claims and prior authorizations. Company ABC then uses a combination of provider contracts (for sub capitated arrangements), member months and actual paid claims data, updated quarterly for all other medical expense categories.

Capitation Revenue
Capitation revenue is accrued and recognized using the number of eligible clients provided by AHCCCS multiplied by the approved rate currently being paid, unless the most recent proposed capitation rates were already approved and are awaiting payment.

Non-Title XIX/XXI Revenue
Non-Title XIX/XXI revenue is accrued and recognized based on the current AHCCCS Allocation Schedule and as documented by Contractor Expenditure Report.

Medical Expenses
BH and PH medical expenses are accrued in the period that services are rendered and are based, in part, on payments and estimates. The total amount of medical expenses recognized includes actual claims payments, capitation payments, and an estimated amount due for claims that have been received but haven't been processed and an estimated amount due for claims that have been incurred but have not been received. All medical expenses are reported net of Medicare.

Administrative Expenses
Administrative expenses are recognized monthly as incurred in accordance with Company ABC's Cost Allocation Plan. Administrative Costs defined by AHCCCS include, but are not limited to management service agreement expenses, professional and outside services, insurance, bank fees, etc. These costs are indirect cost as they are incurred for the common benefit of multiple direct program service activities and are grouped according to the nature of the cost. These costs are allocated in accordance with one of the methodologies described below.

Administrative Cost Allocation Methodologies -
A.) Management Service Agreement Cost - Payment is defined by the management service agreement and is specifically identifiable to individual programs.
B.) Other Administrative Costs are allocated to individual programs based upon proportionate service expense.

Taxes
The Company participates in a tax allocation agreement with Company XYZ and other members of an affiliated group for federal taxes. Within the Company, taxes are allocated to the Acute, Medicare and ALTCS lines of business using the Company's estimated blended effective rate.

Membership
Members are included in the member month calculation for each month, or portion of a month they were enrolled with Contractor. Members who were enrolled less than a month are counted proportionally to the part of the month they were enrolled.

Changes in accounting methodologies
None

3. OTHER AMOUNTS
Describe material amounts included in the "other" and "miscellaneous" categories in the Balance Sheet and Statement of Activities. Material amounts are considered greater than 10% of the related total category (i.e., assets, liabilities, revenues, total other medical expenses or administrative expenses).

Other Income
The amounts reported as Other Income are detailed in the Statement of Activities Schedule A Disclosure and Supplemental Reports.

Miscellaneous Medical Expenses
Non-physician medical expenses and optical expenses are included here

Other Administrative Expenses
The amounts reported as Other Administrative Expenses are detailed in the Statement of Activities Schedule A Disclosure.

Other Current Assets

This includes short-term deferred taxes and expected third party liability revenue. These assets are depicted in the Other Assets Report.

Other Non-Current Assets
Other Non-Current Assets include Long-term deferred taxes.

Other Current Liabilities
This includes premium taxes due to the Department of Insurance, estimated sanction accruals, and Community Reinvestment.

Other Non-Current Liabilities
There are no amounts for non-current liabilities reported.

4. PLEDGES AND ASSIGNMENTS AND GUARANTEES
Describe any pledges, assignments, or collateralized assets and any guaranteed liabilities not disclosed on the balance sheet.
Contractor has no pledges, assignments, or collateralized assets. There are also no guaranteed liabilities not disclosed on the balance sheet.

5. PERFORMANCE BOND
Disclose the method by which the Contractor satisfied the AHCCCS performance bond requirement. This disclosure is required whether or not the amounts are included in the financial statements.

Company ABC has a Surety Bond with Company DEF in the amount of $50,000,000 as of June 30, 2016. This is the amount required by AHCCCS and is not over or under funded.

6. MATERIAL ADJUSTMENTS
Disclose and describe any material adjustments made during the current reporting period. Include those adjustments that may relate to a prior period, specifically IBNR adjustments, that affect the financial statements and provide details for which period(s) the adjustment(s) relates.

An adjustment was made this quarter per the actuary's recommendations for balance sheet reserves. These adjustments occurred in the normal course of business for the Contractor.

7. MEDICAL CLAIMS PAYABLE ANALYSIS
Explain large fluctuations and/or revisions in estimates and the factors that contributed to the change in the Medical Claims Payable balances from the prior quarter. Specifically, address changes of greater than +/-5% of the Total Liabilities for that quarter or the previous quarter if the amount is equal to or greater than +/-5%). Explanations should detail the amount of the adjustments by quarter and by category (PH and BH). For PH, disclose by hospital, medical comp, other and PPC).

Overall, Medical claims payable (line 220) increased $12.0M, or 17.6% over prior quarter.

Amounts:	QE 3/31/2016	QE 06/30/2016	Difference	% Change:
BH Title XIX/XXI	$ 17,582,126	$ 19,357,951	$ 1,775,825	10.10%
BH Non-Title XIX/XXI	13,247,841	14,657,841	1,410,000	10.64%
Physical Health	37,489,329	46,349,272	8,859,943	23.63%
Total:	**$ 68,319,296**	**$ 80,365,064**	**$ 12,045,768**	**17.63%**

For BH: Both Title and Non-XIX/XXI Claims Payable increased primarily due to an increase in authorizations for inpatient services and Home Care Training to Clients.

For PH: Hospital Compensation increased due to an increase in ICU and Rehab unit cost trend. Medical Compensation increased due to an increase in Primary Care Physician Utilization during the quarter. Other Medical increased due to increased unit cost trends primarily in Outpatient and Ambulatory Services. Claims Payable increased slightly for PPC due to an increase in member months.

PH Comparison quarter to quarter on medical claims payable:

Amounts:	QE 3/31/2016	QE 06/30/2016	Difference	% Change:
Hospital	$ 10,578,123	$ 15,369,745	$ 4,791,622	45.30%
Med Comp	11,589,577	15,220,417	3,630,840	31.33%
Other	9,875,525	10,258,147	382,622	3.87%
PPC	5,446,104	5,500,963	54,859	1.01%
Total:	**$ 37,489,329**	**$ 46,349,272**	**$ 8,859,943**	**23.63%**

Claim payment weeks for QE 3/31 = 13 claim payment weeks and QE 6/30 = 13 claim payment weeks. Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by a certified actuary. The Statement of Activities reflects any adjustments made to the reserves. Reserve adjustments are noted on Lag Reports E-4.

8. CONTINGENT LIABILITIES

Provide details of any malpractice or other claims asserted against the Contractor, as well as the status of the case, potential financial exposure and expected resolution.

In the opinion of management, no legal matters exist that would have a material adverse effect on the financial position of Contractor.

9. INVESTMENTS

Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculations of the current ratio, must be disclosed in the footnotes. Descriptions and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20%) Also disclose the amount of Unrealized Gains or Losses reported on the financial statements associated with these investments.

Contractor has no long-term investments that the Contractor would like treated as current assets for calculation of the current ratio.

10. DUE FROM/TO AFFILIATES (CURRENT AND NON-CURRENT)

Describe in detail the composition of the due from/(to) affiliates including the name of the affiliate, a description of the affiliation, amount due from/(to) the affiliate and a description of any significant changes to the line item.

Amount Due From/(To)

Name	QE 03/31/2016	QE 06/30/2016	% Change	Desc of Change
Company M	160,000	140,000	13%	Cash Transactions
Company N	(300,000)	(700,241)	133%	Cash Transactions
Company O	(70,775)	(195,124)	175%	Cash Transactions
Total	**(210,775)**	**(775,365)**	**268%**	

Cash transactions are managed through a main concentration bank account.

11. EQUITY ACTIVITY

Disclose all activity in equity, other than net income or net loss.

The following equity adjustments were made during the quarter ended June 30, 2016:

Month Ending	Unreal Gain/(Losses)	Equity Distribution	Profit(Loss)	Equity Chg
April	157,895	-	4,482,335	4,640,230
May	342,155	-	3,715,345	4,057,500
June	(15,478)	-	2,804,288	2,788,810
Total	**484,572**	**-**	**11,001,969**	**11,486,541**

12. NON-COMPLIANCE WITH FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES

Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve the issue(s), including specifying the expected month that the compliance will be evidenced in the Financial Statements.

FINANCIAL VIABILITY STANDARDS - Year to Date

Current Ratio

Company ABC is in compliance with the Current Ratio.

Equity per Title XIX/XXI Member

Company ABC is in compliance with the Equity Per Title XIX/XXI Member.

PERFORMANCE GUIDELINES

Title XIX/XXI Medical Expense Ratio

Company ABC is in compliance with the Title XIX/XXI Medical Expense Ratio when calculated on a contract year to date basis.

Non-Title XIX/XXI Medical Expense Ratio
Company ABC is in compliance with the Title XIX/XXI Medical Expense Ratio when calculated on a state fiscal year to date basis.

Title XIX/XXI Administrative Cost Percentage
Company ABC is in compliance with the Title XIX/XXI Administrative Cost Percentage when calculated on a contract year to date basis.

Non-Title XIX/XXI Administrative Cost Percentage
Company ABC is in compliance with the Title XIX/XXI Administrative Cost Percentage when calculated on a state fiscal year to date basis.

13. CHANGES IN FINANCIAL STATEMENT ITEMS

Describe changes in balance sheet asset line items if the current or previous quarter amount is equal to or greater than 5% of the total assets for that quarter and the change from the previous quarter exceeds 5%.

Balance Sheet – Assets

A/C	Description	QE 03/31/16	QE 06/30/16	$ Change	QTR % Change	% of Total Assets	Explanation
105	Cash and cash equivalents	46,850,112	44,487,955	(2,362,157)	-5%	38.9%	Decreased due to TXIX Recon recoupment related to CY15.

Describe changes in balance sheet liability line items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Liabilities (for that quarter and if the change from the prior quarter is equal to or greater than +/-5%.

Balance Sheet - Liabilities

A/C	Description	QE 03/31/16	QE 06/30/16	$ Change	QTR % Change	Liabilities	Explanation
215	Physician Payable	12,458,963	10,528,457	(1,930,506)	-15%	19.1%	Med Comp payable decreased quarter over quarter due to favorable claim development driven by a 4% decrease in office visit utilization.
215	Other medical Payable	5,789,123	3,712,589	(2,076,534)	-36%	6.8%	Other Medical payable decreased quarter over quarter due to favorable claim development in Other Medical Comp Utilization most significantly in Other Professional-Ambulance/Transportation. In addition there was a 7% increase in Select Ambulatory paid claims that lowered the Payable amount.
215	BH Payable	7,890,125	4,325,784	(3,564,341)	-45%	7.9%	BH Payable decreased primarity due to payments to PQR Company and STU Company

*Describe changes in Statement of Activities major expense categories for **Title XIX/XXI and Non-Title XIX/XXI** if the current or previous quarter amount is equal to or greater than 5% of the total revenues for that quarter and the change from the previous quarter exceed 5%.*

Statement of Activities

A/C	Description						
	TXIX	QE 03/31/16	QE 6/30/16	$ Change	QTR % Change	% of Total TXIX Revenue	Explanation
501d	Total Treatment Services	49,126,748	55,874,500	6,747,752	14%	12.6%	Treatment services inceased quarter over quarter primarily due to additional Counseling services provided to GMH/SA members during the quarter.
502e	Total Residential Services	14,578,365	22,457,147	7,878,782	54%	5.0%	Residential Services increased due to additional living skills training provided during the quarter for SMI Integrated members.
503e	Total Medical Services	7,852,125	9,845,788	1,993,663	25%	2.2%	No explanation required.
504j	Total Support Services	69,258,142	72,556,942	3,298,800	5%	16.3%	Support services increased during the quarter primarily due to housing and case management. During the quarter, Company ABC purchased two housing units and additional case management services were provided to SMI Intergrated members.
505d	Total Crisis Services	33,001,058	43,578,745	10,577,687	32%	9.8%	Crisis Services increased quarter or quarter primarily due to increased stabilization and emergency transportation costs.
506e	Total Inpatient Services	20,651,489	21,540,158	888,669	4%	4.8%	No explanation required.
507d	Total Residential Services	9,258,560	10,250,357	991,797	11%	2.3%	No explanation required.
508d	Total Behavioral Health Day Program	802,250	818,744	16,494	2%	0.2%	No explanation required.
509c	Total Prevention Services	125,890	175,645	49,755	40%	0.0%	No explanation required.
510d	Total Pharmacy Expense	10,580,458	17,480,785	6,900,327	65%	3.9%	No explanation required.
511	Other Service Expenses	2,280,400	4,899,654	2,619,254	115%	1.1%	No explanation required.
512	BH FQHC/RHC	1,870,682	2,574,231	703,549	38%	0.6%	No explanation required.
408	Primary Care Physician	20,400,895	22,584,580	2,183,685	11%	5.1%	Primary Care Physician expense decreased quarter over quarter driven by a 5% decrease in Office Visit utilization. ABC experienced favorable claim development during the quarter.
419	Outpatient Facility	21,555,789	22,657,489	1,101,700	5%	5.1%	Outpatient Facility expense increased quarter over quarter driven by a 7% increase in OP-ER utilization.
448	Management Fee	15,000,000	17,000,000	2,000,000	13%	3.8%	No explanation required.

14. PHARMACY REBATES/DISCOUNTS

Provide the amount of pharmacy rebates or discounts received that the Contractor has recorded for the reporting period (line 417). Indicate whether or not the pharmacy rebates are either included in or excluded from the Lag Report for Medical Claims Payable.

Also, provide a written statement confirming that rebates do not include restricted drugs that are listed in the AHCCCS Rebate program.

It is estimated that Company ABC will receive 2% of pharmacy costs as rebates. At quarter end, $151,631 is estimated to be received. ABC received $29,544.84 in month/year. Pharmacy rebates are included in the Lag Reports.

15. INTEREST ON LATE CLAIMS

Report interest payments made to providers on late claims. This amount should tie to the interest as reported in the Claims Dashboard for the same reporting period.

Month Ended	Interest Recorded
April	5,412
May	7,859
June	12,478
Total	**25,749**

Company ABC paid $25,749 during the current quarter for interest on late claims. This amount ties to the interest on late claims of $25,749 as reported in the Claims Dashboard for the same reporting period.

16. ACCRUED SANCTIONS

Report any accrued sanctions assessed by AHCCCS, the year-to-date amount of the accrual and the Statement of Activities line item in which they are included.

Company ABC decreased its accrual for sanctions by $250,000 during the quarter ended June 30, 2016. These sanctions have not been finalized and are dependent on CYE 9/30/2016 performance standard results. The expense related to these sanctions is included in Line 458. Total accrued sanctions of $2,200,000 are included on the balance sheet in Line 210.

17. PROVIDER INCENTIVES

Report any accrued sanctions assessed by AHCCCS, the year-to-date amount of the accrual and the Statement of Activities line item in which they are included.

Company ABC paid no provider incentives during the quarter ended December 31, 2016.

18. VALUE BASED PURCHASING INITIATIVES

Report the amounts of any value based purchasing arrangements included in the financial statements.

ABC paid $200,000 in value based purchasing initiatives during the quarter. PH provider JKL received $100,000 which is reported on Statement of Activities line 434. BH provider JKL received $100,000. This amount is reported on line 511.

.

19. NON-COVERED SERVICES

Report the type and amount of any non-covered service included in the financial statements. Indicate the line number and programs in the financial statements where these are reported.

Company ABC has no non-covered services included in the accompanying financial statements.

20. REISURANCE

Provide the following general information: contracted vendor, deductible level and coinsurance. Also provide the following information quarterly: As of date, there was a Reinsurance Recovery of $XXXX and a receivable of $XXXXX recorded for reinsurance.

Company ABC purchased a reinsurance policy to limit the risk of excessive medical expenses.

Contracted Vendor: GHI Company
Deductible: $250,000
Co-insurance: 10% up to $275,000 per covered person
Claims basis: covered expenses incurred and/or paid based on claim date
CYTD there have been no recoveries, so no recoveries or related receivable recorded

21. PRIOR CONTRACT YEAR/PERIOD ADJUSTMENTS

Provide the amount reported on the Prior Contract Year Adjustments Schedule related to a prior contract year(s) and a detailed explanation for the adjustment(s).

Disclose and describe any material prior period adjustment(s) which is equal to or greater than 10% of total revenues or total expenses and is related to a prior quarter within the current contract year.

During the quarter, company ABC recorded an adjusting entry of $500K decreasing Medical Claims Payable for the prior contract year 2015. The details of this adjustment are on schedules E-8a and E-8b.

22. MARKETING COSTS

Include the amount reported on Management Fees (line 448) that is specifically related to marketing costs as delineated in ACOM Policy 404.

During the quarter, Company ABC was allocated $1,500,000 for administrative expenses from the parent company. Approximately $150,000 of this amount was an allocation for marketing costs.

23. BLOCK GRANTS

For SABG, insert a table by allocation category to show how much was expended on a state fiscal year-to-date basis, July 1 – June 30.

For MHBG EBP, footnote the total amount of actual expense (service and administrative) by category as per the Contractors approved plan on state fiscal year-to-date basis, July 1 – June 30. Indicate the type of expense and whether the Contractor is on track to fully expend the funds.

Provide sufficient details explaining why no funds have been expended or if the Contractor is experiencing barriers to spending these EBP funds.

Provide explanations for under/over expending in each block grant category compared to the SABG and the MHBG SED and SMI annual allocations by category. Indicate whether a re-allocation request will be submitted and when. Refer to paragraph 5.09 for additional block grant information.

Company ABC incurred the following SABG expenses on a SFYD basis:

	Service	Admin	Total
General Services	500,000	35,000	535,000
MAT	100,000	7,000	107,000
Children	400,000	28,000	428,000
Preg/Parent	500,000	35,000	535,000
Crisis	300,000	21,000	321,000
Prevention	400,000	28,000	428,000
HIV	250,000	17,500	267,500
Total	2,450,000	171,500	2,621,500

Company ABC expended $200,000 in actual MHBG EBP expenses ($184,000 service, $16,000 admin). The $184,000 was expended on training and materials as outlined in Company ABC's approved EBP plan. There is an allocated balance of $50,000 remaining. Company ABC is on track to fully expend the entire allocation of $250,000.

24. PREMIUM DEFICIENCY RESERVE

Include the cumulative amount of the reserve as well as the current quarter amount and all line items included in the current quarter entry.

During the quarter the Contractor recorded an increase to the Premium Deficiency Reserves in the amount of $2,500,000 to other current liabilities line A/C 240 and other revenue line A/C330. Total Reserves equal $5,000,000.

25. ADDITIONAL EXPENSE EXPLANATIONS REQUESTED BY AHCCCS

Use this footnote to disclose additional information as requested by AHCCCS during the contract year.

a. GMH/SA Duals and CRS Crisis expenses are reported together with GMH/SA Non-Duals Crisis expenses in a single column. Separately identify the crisis amount related to GMH/SA Duals and CRS.
b. Disclose the total amount of County dollars expended on children. Of that amount, how much was expended on remanded juveniles by expense type.

c. Disclose the amount expended on incarcerated adults and children justice programs by Non-Title XIX/XXI funding.

a. The Crisis Expense CYTD total of $1,500,000 includes $500,000 related to GMH/SA Duals and $50,000 related to CRS.
b. Company ABC expended $5M of County dollars on Children Services. Of the $5M, $1M was expended on remanded juveniles primarily for case management services.
c. CYTD, Company ABC expended $2M on incarcerated adults and children justice programs. Of the $2M, $1M was from County dollars and $1M was from Non-Title XIX/XXI.